Contract Number 151473

Oregon Health Authority

AMENDMENT TO
STATE OF OREGON
PERSONAL/PROFESSIONAL SERVICES CONTRACT

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This is amendment number **4** to Contract Number **151473** between the State of Oregon, acting by and through its Oregon Health Authority, hereinafter referred to as "OHA" and

APS Healthcare Quality Review, Inc.
abn KEPRO, Inc.
777 East Park Drive
Harrisburg, PA 17111
Telephone: (717) 564-8288 ext. 7026
E-mail address: jportice@kepro.com

hereinafter referred to as "Contractor."

1. This amendment shall become effective on the date this amendment has been fully executed by every party and, when required, approved by Department of Justice.
2. The Contract is hereby amended as follows:
   a. **Exhibit A, Part 2 - Statement of Work** is hereby amended as set forth in the **Attachment 1** to this Amendment, which is hereby incorporated by this reference, language to be deleted or replaced is ~~struck through~~; new language is **underlined and bold**.
   b. **Exhibit A, Part 3 – Payment and Financial Reporting** is hereby amended as set forth in the attached **Attachment 2** to this Amendment, which is hereby incorporated by this reference, language to be deleted or replaced is ~~struck through~~; new language is **underlined and bold**.
   c. **Exhibit A, Part 4 "Special Provisions", Section 14** is hereby added by this reference effective with execution of this amendment as follows:

      Contractor certifies that Contractor has a written policy and practice that meets the requirements described in House Bill 3060 (2017 Oregon Laws, chapter 212) for preventing sexual harassment, sexual assault, and discrimination against employees

who are members of a protected class. Contractor agrees, as a material term of this Contract, to maintain such policy and practice in force during the entire Contract term.

d. **EXHIBIT B, "Standard Terms and Conditions", Section 10., "Default; Remedies; Termination.", Subsection a. only** to read as follows: language to be deleted or replaced is ~~struck through~~; new language is **underlined and bold.**

a. Default by Contractor. Contractor shall be in default under this Contract if:

(1) Contractor institutes or has instituted against it insolvency, receivership or bankruptcy proceedings, makes an assignment for the benefit of creditors, or ceases doing business on a regular basis; or

(2) Contractor no longer holds a license or certificate that is required for Contractor to perform its obligations under the Contract and Contractor has not obtained such license or certificate within 14 calendar days after OHA's notice or such longer period as OHA may specify in such notice; or

(3) Contractor commits any material breach or default of any covenant, warranty, obligation or agreement under this Contract, fails to perform the Work under this Contract within the time specified herein or any extension thereof, or so fails to pursue the Work as to endanger Contractor's performance under this Contract in accordance with its terms, and such breach, default or failure is not cured within 14 calendar days after OHA's notice, or such longer period as OHA may specify in such notice~~.~~**; or**

(4) Contractor failed to comply with the tax laws of this state or a political subdivision of this state before the Contractor executed this Contract or fails to comply with the tax laws of this state or a political subdivision of this state during the term of this Contract.

e. **EXHIBIT B, "Standard Terms and Conditions", Section 21., "Notice" DHS address only** to read as follows: language to be deleted or replaced is ~~struck through~~; new language is **underlined and bold**.

DHS: Office of Contracts & Procurement
~~250 Winter Street, Room 309~~ **635 Capitol Street NE, Suite 350**
Salem, OR 97301
Telephone: 503-945-5818
Facsimile: 503-378-4324

f. **Amend Attachment 4 – ~~IQA~~ Rates and Metric and Performance Tables** included as Attachments 1 & 2 to this Amendment and hereby incorporated by this reference.

3. Contractor shall comply with all federal, state and local laws, regulations, executive orders and ordinances applicable to Contractor and the Contract. OHA's performance under the Contract is conditioned upon Contractor's compliance with the obligations of contractors under ORS 279B.220, 279B.230 and 279B.235, which are incorporated by reference herein.

4. Except as expressly amended above, all other terms and conditions of the initial Contract and any previous amendments are still in full force and effect. Contractor certifies that

the representations, warranties and certifications contained in the initial Contract are true and correct as of the effective date of this amendment and with the same effect as though made at the time of this amendment.

5. **Certification.** Without limiting the generality of the foregoing, by signature on this Contract Amendment, the undersigned hereby certifies under penalty of perjury that:

   a. Contractor is in compliance with all insurance requirements in Exhibit C of the original Contract and notwithstanding any provision to the contrary, Contractor shall deliver to the OHA Contract Administrator (see page 1 of the original Contract) the required Certificate(s) of Insurance for any extension of the insurance coverage required by Exhibit C of the original Contract, within 30 days of execution of the Contract Amendment. By certifying compliance with all insurance as required by this Contract, Contractor acknowledges it may be found in breach of the Contract for failure to obtain required insurance. Contractor may also be in breach of the Contract for failure to provide Certificate(s) of Insurance as required and to maintain required coverage for the duration of the Contract;

   b. Contractor acknowledges that the Oregon False Claims Act, ORS 180.750 to 180.785, applies to any "claim" (as defined by ORS 180.750) that is made by (or caused by) the Contractor and that pertains to this Contract or to the project for which the Contract work is being performed. Contractor certifies that no claim described in the previous sentence is or will be a "false claim" (as defined by ORS 180.750) or an act prohibited by ORS 180.755. Contractor further acknowledges that in addition to the remedies under this Contract, if it makes (or causes to be made) a false claim or performs (or causes to be performed) an act prohibited under the Oregon False Claims Act, the Oregon Attorney General may enforce the liabilities and penalties provided by the Oregon False Claims Act against the Contractor;

   c. The undersigned is authorized to act on behalf of Contractor and represents and warrants that Contractor has complied with the tax laws of the State of Oregon and the applicable tax laws of any political subdivision of Oregon. Contractor shall, throughout the duration of this Contract and any extensions, comply with all tax laws of Oregon and all applicable tax laws of any political subdivision of Oregon. For the purposes of this Section, "tax laws" includes: (i) All tax laws of Oregon, including but not limited to ORS 305.620 and ORS chapters 316, 317, and 318; (ii) Any tax provisions imposed by a political subdivision of Oregon that applied to Contractor, to Contractor's property, operations, receipts, or income, or to Contractor's performance of or compensation for any work performed by Contractor; (iii) Any tax provisions imposed by a political subdivision of Oregon that applied to Contractor, or to goods, services, or property, whether tangible or intangible, provided by Contractor; and (iv) Any rules, regulations, charter provisions, or ordinances that implemented or enforced any of the foregoing tax laws or provisions.

   Contractor acknowledges that the Oregon Department of Administrative Services will report this Contract to the Oregon Department of Revenue. The Oregon Department of Revenue may take any and all actions permitted by law relative to

the collection of taxes due to the State of Oregon or a political subdivision, including (i) garnishing the Contractor's compensation under this Contract or (ii) exercising a right of setoff against Contractor's compensation under this Contract for any amounts that may be due and unpaid to the State of Oregon or its political subdivisions for which the Oregon Department of Revenue collects debts;

d. The information shown in "Contractor Data and Certification", of original Contract or as amended is Contractor's true, accurate and correct information;

e. To the best of the undersigned's knowledge, Contractor has not discriminated against and will not discriminate against minority, women or emerging small business enterprises certified under ORS 200.055 in obtaining any required subcontracts;

f. Contractor and Contractor's employees and agents are not included on the list titled "Specially Designated Nationals" maintained by the Office of Foreign Assets Control of the United States Department of the Treasury and currently found at: *https://www.treasury.gov/resource-center/sanctions/SDN-List/Pages/default.aspx*;

g. Contractor is not listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal procurement or Non-procurement Programs" found at: *https://www.sam.gov/portal/public/SAM/*;

h. Contractor is not subject to backup withholding because:

(1) Contractor is exempt from backup withholding;

(2) Contractor has not been notified by the IRS that Contractor is subject to backup withholding as a result of a failure to report all interest or dividends; or

(3) The IRS has notified Contractor that Contractor is no longer subject to backup withholding; and

i. Contractor hereby certifies that the FEIN or SSN provided to OHA is true and accurate. If this information changes, Contractor is also required to provide OHA with the new FEIN or SSN within 10 days.

6. **Contractor Data.** This information is requested pursuant to ORS 305.385.

PLEASE PRINT OR TYPE THE FOLLOWING INFORMATION

Contractor Name (exactly as filed with the IRS): APS Healthcare Quality Review Inc. dba KEPRO, Inc.

Street address: 777 East Park Drive

City, state, zip code: Harrisburg, PA 17111

Email address: jportice@kepro.com

Telephone: (717) 564-8288 Facsimile: (717) 564-3862

Is Contractor a nonresident alien, as defined in 26 U.S.C. § 7701(b)(1)?
(Check one box): ☐ YES ☒ NO

Business Designation: *(Check one box)*:

☐ Professional Corporation	☐ Nonprofit Corporation	☐ Limited Partnership
☐ Limited Liability Company	☐ Limited Liability Partnership	☐ Sole Proprietorship
☒ Corporation	☐ Partnership	☐ Other

Contractor Proof of Insurance. Contractor shall provide the following information upon submission of the signed Contract Amendment. All insurance listed herein and required by Exhibit C of the original Contract, must be in effect for the term of the Contract.

If Contractor is self-insured for any of the Insurance Requirements specified in the original Contract, Contractor may so indicate by: (i) writing "Self-Insured" on the appropriate line(s); and (ii) submitting a certificate of insurance as required in Exhibit C of the original Contract.

Professional Liability Insurance Company: Travelers Indemnity Company of America

Policy #: 106295684 Expiration Date: 06/01/2019

Commercial General Liability Insurance Company: Travelers Indemnity Company of America

Policy #: P-6306G63143A Expiration Date: 01/01/2020

Automobile Liability Insurance Company: Travelers Indemnity Co.

Policy #: BA-6G622721 Expiration Date: 01/01/2020

Other #1 (list type of coverage and Company):

Policy #: Expiration Date:

Other #2 (list type of coverage and Company):

Policy #: Expiration Date:

Workers' Compensation: Does Contractor have any subject workers, as defined in ORS 656.027? *(Check one box)*: ☒ YES ☐ NO *If YES, provide the following information:*

Workers' Compensation Insurance Company: Travelers Property Casualty Company of America

Policy #: UB-9H906270 Expiration Date: 01/01/2020

7. **Signatures.**

CONTRACTOR: YOU WILL NOT BE PAID FOR SERVICES RENDERED PRIOR TO NECESSARY STATE APPROVALS.

APS Healthcare Quality Review, Inc.
abn KEPRO, Inc.

By:

Susan T. Weaver, MD
Authorized Signature

Susan T. Weaver, MD
Printed Name

President
Title

January 17, 2019
Date

State of Oregon, acting by and through its Oregon Health Authority

By:

Rhonda Busek
Authorized Signature

Rhonda Busek
Printed Name

Provider Services Director
Title

1-22-19
Date

Approved for Legal Sufficiency:

Via email by Whitney Hill at DOJ
Department of Justice

January 16, 2019
Date

Enter name of any other required Signatures

MC Stanton
Authorized Signature

Margie Stanton
Printed Name

Director
Title

January 24, 2019
Date

ATTACHMENT 1:

EXHIBIT A

Part 2
Statement of Work

1. **General provisions applicable to all Work.**
   - **a.** Contractor shall require Contractor's paid and non-paid employees to treat Fee-for-Service (FFS) Clients with respect and due consideration for his or her dignity and privacy.
   - **b.** Contractor shall foster and promote preventive, community and primary healthcare, including mental and physical healthcare, which aims to keep FFS Clients active, healthy, and independent members of society.
   - **c.** Contractor shall allow the FFS Client to participate in decisions regarding their healthcare, including the right to refuse advice, Program participation, healthcare provider recommendations, and treatments.
   - **d.** Contractor shall, upon a FFS Client's request, provide information on the structure and operation of the Contractor's organization.
   - **e.** Contractor's Work will not include contracting with healthcare provider networks and Contractor will not be the payer of medical treatments or procedures rendered to the FFS Client.
2. **Evidence-based Practices.**
   - **a.** Contractor shall adopt evidence-based practice guidelines that are based on valid and reliable clinical evidence, or on a consensus of healthcare professionals, in consultation with Contractor's participating healthcare providers in the healthcare provider's particular field. Contractor's evidenced-based practice guidelines must consider the needs of FFS Clients.
   - **b.** Contractor shall periodically review, at least annually, and update, as appropriate, its evidence-based practice guidelines.
   - **c.** Contractor shall disseminate the evidence-based practice guidelines to healthcare providers of Clients enrolled in the Program, and, upon request, to OHA, FFS Clients, potential Clients, or Client representatives.
   - **d.** Contractor's decisions for utilization management, coverage of services, or other areas to which the guidelines apply, should be consistent with the adopted evidence-based practice guidelines.
   - **e.** Contractor shall describe in its annual written evaluation of its quality improvement program its process for adoption and dissemination of the evidence-based practice guidelines and identify those that have been adopted.

3. Care Coordination Services.

a. General Provisions for Care Coordination.

(1) Contractor shall provide a comprehensive, seamless, statewide program of Care Coordination services to FFS Clients with a focus on improving healthcare outcomes and eliminating access barriers.

(2) Contractor shall provide Care Coordination services to FFS Clients who meet eligibility criteria as adopted by OHA and described in this Contract. Contractor shall notify FFS Clients eligible for participation in Care Coordination of their potential enrollment in Contractor's Program as described in Section 9 Enrollment.

(3) Contractor shall provide Care Coordination services in accordance with the intent and objectives of OHA's Health System Transformation.

(4) Contractor shall operate its Care Coordination program in accordance with established federal, State, Oregon Health Plan, Oregon Health Authority, and Department of Human Services' statutes, rules, regulations and guidelines.

(5) Contractor shall provide Care Coordination services for FFS Clients with physical health needs, as well as mental health, dental health, behavioral health, long-term care service and support needs, and substance abuse issues.

(6) Contractor shall prioritize its Care Coordination on the identification, engagement, and improved outcomes of high risk, high acuity FFS Clients.

(7) Contractor and OHA shall cooperatively develop a plan to incorporate the Living Well with Chronic Conditions program into the options available to FFS Clients.

(8) Contractor and OHA will seek parallel opportunities for community and provider engagement statewide.

b. Person-Centered Care Coordination.

Contractor's person-centered, integrated Care Coordination shall:

(1) Use evidence-based practices, interventions (as specified in 3.i.(1) below), and strategies that objectively show improved health outcomes, reduce medical costs, and increase the FFS Client's ability to remain independent in Client's own ~~residence~~ **home** or in a ~~Home and~~ ~~C~~**c**ommunity-based ~~Care services (HCBS)~~ setting.

(2) Use health and social services resources that allow FFS Clients with disabilities to live independently at home or with others as long as medically appropriately and safe for the Client.

(3) Focus its Care Coordination program on improving FFS Client health outcomes and eliminating barriers to accessing healthcare services with emphasis on prevention.

(4) Use interventions and strategies that objectively show reductions in the progression of chronic conditions and decreasing acuity/occurrence of catastrophic medical events.

(5) Transition the FFS Client effectively through a continuum of coordinated care services and health care settings using cost-effective Care Coordination within the OHP Medicaid parameters.

(6) Collaborate and coordinate with OHA's Targeted Case Management programs, the Patient Centered Primary Care Homes, and the Coordinated Care Organizations to prevent duplication of efforts and assure FFS Clients' continuity of care between delivery systems.

(7) Focus on effecting the following outcomes:

(a) Improved FFS Client health and reduced medical costs.

(b) Improved access to Patient Centered Primary Care Homes.

(c) Improved access to healthcare services or Targeted Case Management.

(d) Reduced utilization of hospital emergency departments and hospital re-admissions.

(e) Reduced progression of chronic conditions and the acuity of catastrophic medical conditions.

(f) Improved utilization of behavioral health services provided in outpatient and licensed residential and inpatient settings.

(g) Decreased wait time for individuals waiting to be discharged from the Oregon State Hospital.

c. Care Coordination Health Stratification Process.

(1) Contractor shall use a mutually agreed upon health stratification process that assigns FFS Clients to unique care coordination categories based on clinical, functional, and social needs, patterns of risk for disease, and expected resource requirements.

(a) Contractor's health stratification process shall ensure the correct coordinated healthcare services are provided to FFS Clients.

(b) Contractor shall ensure that the FFS Clients are accurately identified and managed at the most appropriate level of intervention using a one through five acuity ranking and as defined by Contractor's risk stratification criteria and/or other mutually agreed upon acuity rankings.

(c) Contractor shall affirm FFS Client's clinical stratification and risk assessment as appropriate to the FFS Client's needs.

(d) Contractor's health stratification process must be based on an analysis of Medicaid claims using a predictive modeling process which assigns FFS Clients to unique, mutually-exclusive, morbidity categories based on patterns of risk for disease and expected resource requirements.

(2) Contractor shall ensure Care Coordination services are provided to the FFS Clients identified through the health stratification process in subsection (1) above.

(3) Contractor shall ensure the type, frequency and intensity of FFS Client interventions are determined based on a health stratification process and acuity level Contractor establishes for FFS Client.

(4) In addition to Contractor's health stratification process, Contractor shall apply and utilize financial cost data for the past 12 months, co-morbidities for the past 12 months, multiple utilization patterns, and lack of ambulatory care within the past six months, as applicable.

(5) Contractor shall move the FFS Client between clinical stratification and risk assessment levels when indicated by the FFS Client's needs. FFS Client's movement between acuity levels and the final determination of acuity levels shall be based upon the following:

(a) The completed initial assessment;

(b) The clinical stratification and risk assessment process; and

(c) The registered nurse or primary care manager's determination during subsequent telephonic or in-person interventions.

d. Immediate Care Coordination.

Contractor may prioritize FFS Clients for immediate Care Coordination services when one of the following occurs:

(1) FFS Client is determined to be at risk through the daily health stratification and risk assessment process.

(2) Intervention algorithms, healthcare follow-up, or health assessments are obtained through the NAL.

(3) Health assessments conducted by Contractor's Care Coordination program staff identify the need for immediate Care Coordination services.

(4) Healthcare facility or clinic and community-based outreach efforts by Contractor.

(5) Real-time referrals from OHA, healthcare providers, or other health entities, agencies, or members of the FFS Client's family.

e. Care Coordination Eligibility. Contractor shall verify the FFS Client's eligibility, benefit package, service provider status, and funded service coverage for Care Coordination services. Contractor will use the Medicaid Management

Information System (MMIS) to determine FFS Client's benefit package and coverage.

f. Care Coordination Initial Assessment.

(1) Contractor shall locate and attempt to contact all newly enrolled OHA FFS Clients. Contractor will outreach to high acuity (4-5) FFS Clients within 30 days after enrollment as a FFS Client and will outreach to moderate (1-3) acuity FFS Clients within 60 days after enrollment as a FFS Client.

(2) Contractor shall perform an initial assessment of all new FFS Clients identified by OHA within 90 days after the first successful attempt to contact the FFS Client. Contractor shall use the initial assessment to obtain an understanding of the FFS Client's risks, chronic conditions, or disease processes in order to develop individualized care management action plans, prioritize interventions, and plan Care Coordination follow-up. The FFS Client's initial assessment shall include:

(a) Diagnosis and medical history.

(b) The presence or absence of routine sources of care.

(c) Recent signs and symptoms associated with any identified chronic illnesses.

(d) Primary disease processes and co-morbidities.

(e) Current treating health professionals and medications.

(f) Any cultural factors about healthcare which influence access, receptivity, or service provider behavior.

(g) Risk for depression and substance abuse.

(3) Contractor shall provide health literacy assessments to measure the degree to which the FFS Client has the capacity to understand basic health information and services to make appropriate health decisions.

g. Contacts with Fee-for-Service Clients for Care Coordination.

(1) Contractor shall contact the FFS Client as frequently as required by the FFS Client's clinical and social service needs. Contractor shall ensure that frequency of contact and any interventions are prioritized regularly based on those needs and are aimed at the FFS Client's goal achievement and improved clinical outcomes.

(2) Prioritization of FFS Clients for in-person contact is based on claims, prior assessments, and other information available to Contractor that assists Contractor in determining the appropriate Care Coordination services.

(3) Initial contacts with the FFS Client for Care Coordination must be made by Contractor's care coordinator, a registered nurse or a primary care manager.

(4) Contractor shall, at each subsequent contact with the FFS Client, review assessments and assessed acuity level, diagnosis, and medical history and

update the FFS Client's information and plan-of-care as indicated during the contact. Updates to the FFS Client's clinical information shall include assessments for behavioral and mental health problems that are clinically relevant in the judgment of the registered nurse or the clinician.

(5) Contractor shall follow up based on clinical discretion. Contractor shall adjust the frequency of the registered nurse or primary care manager's support for FFS Client as the FFS Client progresses toward meeting the goals developed and stated in the FFS Client's individual plan-of-care.

h. Plan-of-Care.

(1) Contractor shall prepare a plan-of-care for each assessed and engaged FFS Client and schedule regular follow-up with a registered nurse or primary care manager as part of Contractor's Care Coordination and as based upon the FFS Client's specific healthcare needs. Each FFS Client plan-of-care will be stored on Contractor's operating system.

(2) Contractor shall prepare the plan-of-care after Contractor's initial assessment with each FFS Client. The plan-of-care must address identified areas of risk for the FFS Client and include goals established with the FFS Client. The plan-of-care must support the ability of the FFS Client to be safely and effectively maintained in the setting of their choice and at the most efficient and effective level of care. The FFS Client's plan-of-care must support the FFS Client's Patient Centered Primary Care Home (PCPCH) whenever possible.

(3) A FFS Client's plan-of-care must include ongoing assessments of the FFS Client's health and:

(a) Instruction and support of the FFS Client's ability to practice self-management skills.

(b) Instruction and assistance in securing supportive resources.

(c) Education, information, and referrals for tobacco cessation and avoidance of second-hand smoke.

(d) Screenings for depression, behavioral and mental health considerations, alcohol and substance abuse, dementia and other most common co-morbid conditions as part of the clinical assessment.

(e) Education and assistance with the reduction or elimination of barriers to care.

(f) Assessment of the FFS Client's medication knowledge and compliance.

(g) Assessment of the FFS Client's receptivity to healthcare provider communications and instructions to improve the FFS Client's dialog with those providers.

(h) Education and information on the use of medical resources, such as emergency room services and crisis centers in support of the FFS Client's PCPCH.

(i) Provision of information about advance directives and determination of the presence or absence of advance directives.

(j) Assessment of the FFS Client's understanding of his or her individualized plan-of-care.

i. Care Coordination interventions.

Contractor's Care Coordination services must provide interventions based upon an assessment of the FFS Client's healthcare needs. The interventions must be consistent with evidence-based practices, clinical guidelines, and recommended treatments for the FFS Client's disease status, and be specific to the FFS Client's acuity level and need. Contractor shall ensure the type, frequency, and intensity of interventions are based on the risk and acuity level established for the FFS Client by the Contractor.

(1) Care Coordination interventions include the following:

(a) Assistance with coordination of resources, including medical needs and ancillary services.

(b) Assistance with medical appointments and in locating transportation services.

(c) Adjustments in living arrangements.

(d) Coordination and assistance in maintaining healthcare services and activities of daily living.

(e) Assistance with discharge and post-discharge planning:

i. Discharge planning from inpatient to nursing facility or home-based or community living;

ii. Discharge planning from nursing facility to home-based or community living.

(f) Coordination of FFS Client's benefits for a period of time appropriate to and dependent upon diagnosis and needs.

(g) Communication with FFS Client, healthcare providers, healthcare facilities, OHA, DHS-APD, and family or care givers about treatment needs and development of plans-of-care.

(h) Facilitating communication with healthcare service and clinical providers to address primary healthcare issues, clinical or social services alerts; to identify gaps in service or care; and to increase utilization related to FFS Client's assessed and self-reported needs.

(i) Coordination of referrals to appropriate groups for support, activity, recreation, social services, legal and financial counseling, and respite care.

(j) Assistance with eliminating barriers to healthcare with the goal of improved self-sufficiency.

(k) Education on healthcare practices needed for self-improvement and maintaining independence that is culturally and linguistically appropriate.

(2) Contractor shall prioritize the type of interventions on an ongoing basis aimed at achievement of Care Coordination goals and improved health outcomes.

j. Contractor shall track and monitor the FFS Client's progress and clinical outcomes toward the Client's identified clinical outcome objectives and goals.

k. Contractor shall support FFS Client placement in a PCPCH and shall assist OHA in finding PCPCHs for FFS Clients. Contractor shall encourage and promote the benefits of a PCPCH for FFS Clients.

l. Contractor shall collaborate and coordinate:

(1) with the PCPCH care teams to provide interventions, assistance, consultation, transition, and discharge;

(2) with inpatient, outpatient, long term services and supports, emergency departments; and

(3) with other care plan activities to promote and support the FFS Client in the PCPCH environment.

m. Contractor shall support the use of, and refer the FFS Client to, chronic disease self-management community-based programs, tobacco cessation services, and appropriate evidence-based prevention screenings and procedures. Contractor shall ensure referrals are condition, age, and gender appropriate for the FFS Client.

n. Contractor shall provide appropriate FFS Client referrals and follow-ups with dental health providers.

o. Contractor shall assist OHA and DHS-APD in the determination of appropriate Care Coordination services for activities of daily living, occupational therapy, physical therapy, private duty nursing, medication management, and post discharge transition of care.

4. Comprehensive Care Coordination.

a. Contractor shall provide professional, comprehensive, Care Coordination management to OHA.

b. Contractor shall consult with OHA when requested and shall make recommendations on Care Coordination for FFS Clients.

c. Contractor shall evaluate and provide input on current Care Coordination practices and identify improvement opportunities to benefit FFS Clients.

d. Contractor shall collaborate with OHA and other OHA contractors to develop and facilitate opportunities to meet mutual Care Coordination goals.

e. Prior Authorization and Claim Re-evaluation. Contractor shall conduct prior authorization and claim re-evaluation services **using the following procedures** only for the programs and member benefit groups as follows:

- Prior Authorization of behavioral health services provided to members residing in OHA licensed residential treatment programs **who are not 1915(i) eligible** ~~as described in Section 7d. (Medical Appropriateness Review services);~~ and
- Re-evaluation of claims for emergency medical services covered through the Citizen Alien Waived Emergent Medical (CAWEM) benefit.

Procedures: Contractor shall complete prior authorization **(PA)** and claim re-evaluation work as follows:

(1) Complete evaluations and PAs according to appropriate Oregon Administrative Rules (OAR).

(2) Complete evaluations and PA's in accordance with Health Evidence Review Commission's Prioritized List per OAR.

(3) Complete processing of PAs for the Electronic Document Management System's (EDMS) load time as follows:

(4) Immediate Requests will be completed within 24 hours of receipt. (Important: Emergency services do not require PA)

(5) Urgent Requests will be completed within 72 hours of receipt

(6) Routine Requests will be completed within 10 business days of receipt.

(7) Complete PAs using OHA's Medicaid Management Information System (MMIS) PA subsystem. Document decisions and clinical judgment within this system.

(8) Implement process for individual case referral from Utilization Management (UM) to Case Management (CM) for comprehensive care coordination of potential cases identified through PA requests.

(9) Work with OHA to develop necessary reports to share on file sharing system (see section 13) that will include at a minimum number of PA's received, type of PA, number approved, number pended, number denied, number of PA's handled by reviewer, and number referred for Medical Management review.

(10) Ensure that staff conducting PA evaluations have adequate knowledge of the Oregon Administrative Rules and Prioritized List of Health Services including amendments and changes that are routinely made.

5. Disease Management and Intensive Care Management Services.

a. General Provisions for Disease Management (DM) and Intensive Care Management (ICM).

(1) Contractor's coordination of DM and ICM shall:

(a) Integrate evolved and innovative person-centered coordinated care practices into a quality, comprehensive, delivery model.

(b) Focus on the FFS Client to meet Client's healthcare needs in a holistic and comprehensive approach.

(c) Take into account cultural, educational, social, mental, behavioral, and economic issues that affect the FFS Client's ability to manage their condition, illness, or disease.

(d) Connect FFS Clients to services that reduce the FFS Client's chances of catastrophic or severe illness or unnecessary utilization of costlier healthcare or levels of service.

(2) Contractor shall coordinate DM and ICM services for FFS Clients with complex health needs, as well as mental health, dental health, behavioral health, long-term service and support needs, and substance abuse issues.

(3) Contractor shall notify FFS Clients eligible for participation in DM or ICM of their potential enrollment in Contractor's Program as described in Section 9 Enrollment.

b. DM and ICM Stratification Process.

(1) Contractor's DM and ICM services shall be provided to FFS Clients who are identified as high risk, high acuity through the Contractor's health stratification and risk assessment processes.

(2) Stratification for DM and ICM services must be based on the Chronic Disease and Illness Payment System (CDPS) which assigns FFS Clients to unique, mutually-exclusive morbidity categories based on patterns of disease and expected healthcare resource requirements.

(3) Contractor will stratify or affirm FFS Clients' acuity stratification monthly.

c. DM and ICM Assessments.

Contractor's DM and ICM assessments specific to FFS Clients in high acuity, high risk may include the following:

(1) Review of waiver program benefits to determine the appropriateness of healthcare services.

(2) A transition of care assessment and medication management when indicated.

(3) An assessment of the understanding by the FFS Client and the Client's healthcare provider of the key elements of the necessary interventions and approach to care.

d. DM and ICM interventions.

Contractor shall provide face-to-face or in-person DM or ICM interventions to high risk, high acuity FFS Clients in the FFS Client's residence when:

(1) The registered nurse or primary care manager determines that the FFS Client cannot be effectively managed telephonically, or

(2) The registered nurse or primary care manager determines that the FFS Client's residence is the only environment DM or ICM interventions could be effectively provided; or

(3) Contractor is unable to utilize local, community, public health resources; or

(4) No other State funded registered nurse home-based care is being provided; or

(5) When directed by OHA or DHS-APD.

An exception may be made to providing face-to-face, in-person interventions in the FFS Client's residence when there is an imminent risk or threat to the safety of the FFS Client or the Program staff.

e. Disease Management Eligibility.

FFS Clients are eligible to receive Contractor's DM services when OHA eligibility criteria are met and through at least one of the following:

(1) The FFS Client's monthly health stratification and risk assessment process.

(2) The intervention algorithms, follow-up contacts, or assessments obtained through a NAL contact.

(3) The health assessments conducted by Contractor's healthcare staff.

(4) Contractor's outreach activities with healthcare facilities or clinic and community-based programs.

(5) Referrals to Contractor from OHA, healthcare providers, other healthcare entities or agencies, or the FFS Client's family members.

f. Disease Management.

(1) Contractor must stratify the FFS Client receiving DM services into one of three risk acuity levels: high (4-5), moderate (1-3) or low (0).

(2) Contractor shall ensure that the FFS Client accessing the DM services through the Contractor's Program is accurately identified as high, moderate or low acuity, as defined by the Chronic Disease and Illness Payment System (CDPS) stratification criteria.

g. Intensive Care Management Eligibility.

FFS Clients are eligible to receive Contractor's ICM services when OHA eligibility criteria are met and through at least one of the following:

(1) The FFS Client's monthly health stratification and risk assessment process.

(2) The intervention algorithms, follow-up contacts, or assessments obtained through a NAL contact.

(3) The health assessments conducted by Contractor's healthcare staff.

(4) Contractor's outreach activities with healthcare facilities or clinic and community-based programs.

(5) Referrals to Contractor from OHA, healthcare providers, other healthcare entities or agencies, or the FFS Client's family members.

h. Intensive Care Management.

(1) Contractor shall coordinate ICM services for FFS Clients including intervention services, physical and oral health services, behavioral health services, and children and youth services.

(2) Contractor shall coordinate with OHA and DHS-APD and affiliated agencies to increase awareness and utilization of existing ICM resources that would be beneficial to FFS Clients.

(3) Contractor shall coordinate with other community healthcare providers, including home health, cardiac rehabilitation, physical therapy, psychiatric clinicians, and other medically related support services, to assist FFS Clients receiving ICM services to meet goals set in the FFS Client's plan-of-care.

(4) Contractor shall provide ICM services in the FFS Client's home or community as appropriate for the FFS Client.

(5) Contractor shall provide ICM services to FFS Clients identified as having immediate or emergent acute care or transition needs, frequent emergency department utilization or hospitalization, or co-morbid conditions that require complex medical care management services, to assist the FFS Client to cope with their acute condition.

(6) Contractor shall transition the FFS Client, who was previously in lower risk, lower acuity Care Coordination program, from the Contractor's ICM program back to the FFS Client's registered nurse or primary care manager for continued support.

i. DM and ICM Outcomes.

Contractor's program for DM and ICM shall make reasonable best efforts to:

(1) Reduce per Client healthcare costs and long term care and support costs by:

(a) Reducing hospitalization of ambulatory care sensitive conditions.

(b) Reducing non-emergent utilization of emergency departments.

(c) Reducing tobacco and chemical dependency.

(d) Reducing the number of under-immunized children and adults.

(e) Enhancing, supporting, and incorporating self-management skills and healthy lifestyles.

(2) Reduce barriers to care from both the FFS Client's and healthcare provider's perspective.

(3) Reduce need for long term skilled nursing facilities from forecasted projections.

(4) Increase in-home residency from forecasted projections.

(5) Maintain or improve health functioning of long-term services and support recipients.

(6) Maintain or improve health functioning of long-term psychiatric care recipients.

j. Contractor shall work collaboratively with OHA's Pharmacy Clinical Services Contractor to synergistically monitor pharmacy utilization and improve compliance, thus improving health outcomes.

k. Contractor shall work with OHA staff to identify subpopulations that require interventions targeted to reduce disparities and improve health outcomes or improve access to services. This includes access monitoring plans and consultation and reporting to advise OHA and provide recommendations on how to solve issues identified.

6. Nurse Triage and Healthcare Advice Line.

a. General Provisions for the Nurse Triage and Healthcare Advice Line (NAL).

(1) Contractor's NAL services must include:

(i) Evidence-based resolution algorithms,

(ii) Decision support,

(iii) Language translation or interpreter services,

(iv) Culturally sensitive triage and healthcare advice,

(v.) Remote 911 report and hold capability,

(vi) Screening for FFS Client eligibility and insurance plan or CCO enrollment, and

(vii) Point-in-time direct call transfers.

(2) Contractor's NAL services shall not discriminate between FFS Clients or vary its NAL services for those FFS Clients receiving specific Care Coordination, Disease Management, or Intensive Care Management services.

b. Contractor shall provide the NAL for all FFS Clients. Contractor's NAL shall be a toll-free number that is available 24 hours per day, seven days per week, including holidays, and 365 days per calendar year.

(1) The Contractor's Oregon NAL hours of operation shall be 8:00 a.m. to 5:00 p.m. Pacific Time.

(2) The Contractor's alternative NAL hours of operation shall be 5:00 p.m. to 8:00 a.m. Pacific Time.

c. Contractor's personnel who answer triage and healthcare calls and manage clinical triage services shall be registered nurses or disease management coordinators with the same availability schedule as subsection b above. All clinical triage services must be managed by a registered nurse. The registered nurses or disease management coordinators who staff the NAL will answer all calls and ascertain the FFS Client's symptoms or condition and will follow approved triage algorithms when transferring and assigning the call.

d. Contractor shall have protocols to direct FFS Clients accessing the NAL for triage services and healthcare advice to the most appropriate level of service and type of care required for the FFS Client's symptoms or condition.

e. Contractor shall ensure that FFS Clients are transitioned to and followed by Contractor's Care Coordination staff resources to manage the FFS Client's healthcare. FFS Clients receiving DM or ICM services will be referred to and followed by Program staff previously assigned to the FFS Client.

f. Contractor shall have procedures for FFS Client follow-up to NAL services. Contractor's procedures must provide follow up Care Coordination services by Contractor's staff within 72 hours of the initial NAL contact and interaction with the FFS Client. Contractor shall follow the referred or transferred FFS Client and shall maintain documentation of the result of the referral or transfer to indicate the progression to Care Coordination, Disease Management, or Intensive Care Management.

g. Contractor shall immediately contact the local police, fire, or medical rescue agency (911) to alert authorities when, in the opinion of the Contractor's NAL staff, there is a suspicion of domestic violence, elder abuse, or other abuse or emergent situations requiring emergency response.

h. Contractor shall have Process Improvement or Quality Control measures to demonstrate caller satisfaction with the NAL services as described in Section 12 Evaluation; Quality Control; and Process Improvement.

i. Contractor shall require any approved Subcontractors who are providing NAL services to adhere to the same standards as required of Contractor. Contractor shall obtain OHA approval of all subcontracted NAL services pursuant to Exhibit B paragraph 18. Contractor shall be responsible to monitor the Subcontractor's service levels for compliance to the standards established by OHA and Contractor.

j. Contractor's NAL services shall include educational information as appropriate for telephonic services and referrals to available sources of healthcare education and instruction.

k. Contractor shall prepare written monthly reports of all NAL interactions as described in Section 13 Data, Records, and Reports.

7. Independent and Qualified Agent Services per the 1915(i) Home and Community Based Services (HCBS) State Plan Amendment

~~a.~~ ~~Based upon the standards defined in this Contract, Contractor shall perform the duties of the Independent and Qualified Agent (IQA) to determine service eligibility, perform needs based assessments, review participant service plans, prior authorize HCBS and fee for service services, conduct medical appropriateness reviews (utilization management) and perform transition management and planning for recipients determined ready to transition between among levels of care~~

a. Qualifications: ~~b.~~ Unless otherwise specified, Contractor shall ensure **Independent and Qualified Agent (**IQA**)** services are performed by ~~a staff~~ **an individual** who is a Qualified Mental Health Professional (QMHP) meeting the following qualifications:

A Licensed Medical Practitioner;
A graduate degree in psychology, social work, or recreational, art, or music therapy;
A graduate degree in a behavioral science field;
A bachelor's degree in occupational therapy and licensed by the state of Oregon; or
A bachelor's degree in nursing and licensed by the State of Oregon.

AND

Education and experience which demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; ~~document a multi-axial DSM diagnosis;~~ write and supervise a treatment plan, conduct a comprehensive mental health assessment; and provide individual, family, and/or group therapy within the scope of practice.

b. Summary of Independent and Qualified Agent (IQA) duties:

As the chosen IQA as defined in and accordance with 42 CFR 441.730 and referenced in Oregon's 1915(i) State Plan Amendment (SPA), Contractor implements the 1915(i) State Plan HCBS program benefit to eligible recipients. The 1915(i) program benefit is a Long-term Service and Support benefit to include: choice of provider among HCBS settings[1] and the following services: Home based habilitation, HCBS Behavioral Habilitation

[1] **1915(i) SPA HCBS Settings do not include SRTFs. See OAR Chapter 411 Division 004.**

and HCBS Psychosocial Rehabilitation for persons with Chronic Mental Illness.

~~Contractor shall utilize accredited, and/or evidence based, and generally accepted decision support criteria when performing prospective, concurrent and retrospective review activities.~~

Based upon the standards defined in this Contract **and Oregon's 1915(i) HCBS SPA,** Contractor shall perform the duties of the Independent and Qualified Agent (IQA) to **include the following discrete services:** determine ~~service~~ **1915(i) program** eligibility, perform ~~needs based assessments~~ **functional needs assessments, create and** review **Recipients'** ~~participant~~ **person-centered** service plans, ~~prior authorize HCBS and fee for service services~~, conduct medical appropriateness reviews **of 1915(i) HCBS SPA services,**~~(utilization management)~~ and perform transition management and planning for **R**~~r~~ecipients **transitioning among HCBS settings based on Recipient's choice of provider or desire to reside in a non-licensed setting (their own residence).** ~~determined ready to transition between among levels of care~~

c. 1915(i) Eligibility Determination and Re-determination.

(1) General Provisions of 1915(i) Eligibility Determination and Re-determination.

(a) Contractor shall evaluate whether individuals meet needs-based eligibility using the process and criteria described in Oregon's 1915(i) HCBS **S**~~s~~tate **P**~~p~~lan ~~option~~**Amendment. Individuals must**:

1. **Have been diagnosed with a chronic mental illness as defined in ORS 426.495; (c)(B);**
2. **Be age 21 years or older;**
3. **Require receipt of at least one 1915(i) HCBS service monthly; and**
4. **Have a need for assistance in two or more areas of Instrumental Activities of Daily Living (IADL) due to the symptoms of a behavioral health condition.**
5. **IADLs include, but are not limited to, housekeeping including laundry, shopping, transportation, medication management, and meal preparation.**

(b) Contractor **shall** conduct~~s~~ a face-to-face independent functional needs assessment of individuals determined to be eligible for the 1915(i) HCBS State Plan ~~Option~~ **Amendment** benefit. The needs assessment **must** meet~~s~~ federal requirements at 42 CFR §441.720.

(c) Contractor shall conduct a face-to-face reassessment of individuals' functional needs ~~at least~~ every 12 months, **or** as needed when the individual's circumstances or needs change

significantly, **or** at the request of the individual as required under 42 CFR §441.720(b).

(d) Based on the independent functional needs assessment, contractor shall develop a person-centered service plan for each individual determined to be eligible for the 1915(i) HCBS State Plan ~~Option~~ **Amendment**. Contractor shall develop the person-centered service plan using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the resulting written person-centered service plan meets federal requirements at 42 CFR §441.725(b) **and according to subsection 7.c.(3) below of this Contract**.

(e) Contractor shall review and revise the person-centered service plan upon reassessment of functional need as required under 42 CFR §441.720, ~~at least~~ every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

(f) No 1915(i) HCBS setting (AFH/RTH/RTF) is reviewed for medical appropriateness. The Recipient's choice of 1915(i) HCBS setting is considered medically necessary pursuant to OAR 410-120-0000(146)(d) and is Prior Authorized when the Recipient is deemed eligible for 1915(i) HCBS.

(g) The following services are Prior Authorized if medically appropriate as determined through a functional needs assessment and the person-centered planning process and on the same timeline as the person-centered planning process described in 7.c.(1)(c) above:

- **Home Based Habilitation**
- **HCBS Behavioral Habilitation**

~~(f)~~**(h)** Contractor shall develop an electronic database to track the receipt, content, and outcome of the Referral. Contractor shall electronically archive the Referrals and the clinical documentation accompanying each request. Contractor shall provide OHA access to the archived documentation.

(i) ~~(g)~~ Contractor shall develop a website for use by individuals and providers seeking information on making a Referral or getting 1915(i) HCBS ~~services~~. Contractor shall include relevant information, links, forms and contact information. OHA shall have the right to review and approve content of the website and to retain ownership upon expiration or termination of this Contract.

(j)~~(h)~~ Contractor shall develop communication materials that describe the Referral, eligibility determination, and independent assessment

processes. **OHA must approve Contractor's communication materials prior to use.**

(k) ~~(i)~~ Contractor shall determine whether the Recipient meets the ~~following~~ eligibility requirements **in 7.c.(1)(a) above and** in the most current CMS-approved 1915(i) HCBS State Plan ~~Option~~ **Amendment**, using the criteria and process ~~described~~ as ~~follows~~ **defined in** subsection **(2) 1915(i) Eligibility Process**, **below.**

(2) 1915(i) Eligibility ~~(2)~~ Process

(a) Contractor receives requests for eligibility determinations for individuals who are potentially eligible for 1915(i) HCBS from a referrer.

(b) Contractor works with the ~~person~~ **Recipient** and/or his/her **authorized** representative**, if applicable,** to establish a time to engage with the ~~person~~ **Recipient** in his/her current location or a location of the ~~person~~ **Recipient's** choosing. When establishing an initial meeting, the IQA case manager will inform the ~~person~~ **Recipient** of his/her choice to include others that may have information about his/her needs or people who are important to and provide support for the ~~individual~~ **Recipient**.

(c) Contractor shall provide necessary information in plain language in a manner accessible to individuals with disabilities and persons whose English proficiency is limited. Cultural factors must be considered.

(d) Contractor conducts a face-to-face needs assessment with the ~~individual~~ **Recipient**, the ~~individual~~ **Recipient**'s authorized representative**, if applicable,** and in consultation with other persons identified by the **Recipient** to determine if the **Recipient** is eligible based on the diagnostic and needs-based criteria defined in the 1915(i) State Plan ~~Option~~ **Amendment**.

(e) Contractor performs needs-based assessment through review of necessary clinical information, consultation with the **Recipient** ~~individual~~, **Recipient's** authorized representative**, if applicable,** and other persons important to the ~~individual~~ **Recipient or** who have knowledge of the ~~individuals~~ **Recipient's** service and support needs.

(f) As part of the person-centered needs assessment process, contractor uses the Level of Care Utilization System (LOCUS) and the Level of Service Inventory (LSI) as part of the overall package of information used to determine whether ~~a~~**n** Recipient meets the needs-based criteria for 1915(i) HCBS State Plan ~~Option~~ **Amendment**. ~~Contractor may suggest use of a different standardized assessment as part of the person-centered plan and~~

~~upon OHA/CMS approval, may use an assessment tool other than LOCUS or LSI.~~

(g) If it is determined the person is not eligible based on the needs-based criteria, contractor shall notify the person and his/her **authorized** representative**, if applicable,** in writing within three business days. **Contractor shall use the form provided by OHA and shall provide hearing rights. OHA shall provide the hearing through the Office of Administrative Hearings and Contractor shall cooperate with the hearings process including but not limited to provision of evidence and testimony.**

(h) If it is determined the person is eligible for 1915(i) HCBS, contractor shall **then** conduct a person-centered plan**ning process described in subsection 7.c.(3) below,** to document the **Recipient** ~~person~~'s needs and choices in a person-centered service plan **created by the Contractor.**

(i) Contractor shall make reasonable effort to connect with the Recipient to develop a person-centered plan. Inability and/or lack of response from the Recipient will be appropriately documented.

(3) Person-Centered Service Plan

(a) Person Centered Service Planning General Requirements

Person-centered planning process shall be according to 42 CFR §441.725(a). During the initial interaction, **prior to creating the** ~~to develop the~~ person-centered **service** plan, Contractor shall provide information to the person (and/or those individuals chosen by the ~~person~~ **Recipient**) regarding eligibility and referral processes, available benefits, resources, services and supports covered under the 1915(i) HCBS.

Information shall be provided by Contractor ~~verbally~~ **orally** and in writing in a manner and language easily understood by the ~~person~~ **Recipient** and others the ~~person~~ **Recipient** has chosen to participate in the **functional needs assessment and** person-centered ~~assessment and~~ planning process**es**. Contractor shall develop print and online information about **1915(i)** home and community-based services and supports that includes information about providers and services and how to access them~~.~~**; Prior to Contractor's use of any informational material, Contractor shall submit such materials to OHA for review and approval.**

Through the person-centered assessment and planning process**es**, Contractor shall assist ~~person~~ **Recipient** to identify **and choose** the services, supports and benefits to assist him/her to achieve the goals or outcomes the Recipient has identified as important.

During this process, Contractor shall provide education, instruction and information about the person-centered assessment and planning process**es**, and how ~~it is~~ **they are** applied, the range and scope of ~~individual~~ **Recipient** choices and options, the process for changing the person-centered service plan, grievance and appeals process, Recipient rights, risks and responsibilities of self-direction, free choice of providers, service delivery models, **choice of 1915(i) HCBS settings**, reassessment and review schedules, defining goals, needs and preferences, identifying and accessing services, supports and resources, development of risk management agreements, and recognizing and reporting critical events, including abuse investigations.

(b) Standards for Person-Centered Planning services shall be implemented as required to serve the ~~individual~~ **Recipient**.

For each Recipient determined eligible **initially and annually thereafter** for 1915(i) services, Contractor shall develop a **person-centered service** plan ~~of care~~ that reflects the services and supports, and the delivery of such services and supports, which are important to the Recipient **and meet the Recipient's assessed needs**. The Recipient directs the process to the maximum extent possible and is enabled to make informed choices and decisions. Persons chosen by the Recipient are included in the planning.

The person-centered plan shall be according to 42 CFR §441.725(b). At initial eligibility and at subsequent eligibility redetermination, Contractor shall ~~prepare~~**draft or update** ~~the~~ **Contractor's** written **person-centered service** plan **that is commensurate with:** ~~of care~~ **(1)** ~~commensurate with the individual's level of need~~ **Recipient's needs based on a functional needs assessment** and **(2)** the scope of the services and supports available that reflect~~s~~ the ~~individual~~ **Recipient**'s strengths and preferences and includes individually identified goals and desired outcomes.

In the person-centered service plan, Contractor shall describe any clinical and support needs identified through a functional needs assessment and indicate the paid and unpaid services and supports and the providers responsible for implementation.

In the person-centered service plan, Contractor shall include risk factors and measures to minimize the risk factors, such as individualized backup plans and strategies.

In the person-centered service plan, Contractor shall document and justify any modification that supports a specific and individualized assessed need.

Contractor shall **send** ~~make~~ a copy of the **person-centered service** Plan ~~available~~ to the ~~person~~ **Recipient**, the ~~person~~ **Recipient's** ~~personal~~ **authorized** representative **(if applicable)**, the ~~person~~**Recipient's** care coordinator and any applicable providers of HCBS~~services~~.

(c) **Eligibility** Process requirements

Contractor shall complete the face-to-face eligibility determination review within three business days of receiving the Referral. Contractor shall complete urgent requests for an eligibility determination within 48 hours not to exceed two business days of receiving the completed Referral.

Contractor shall provide written notification of the eligibility determination outcome to the **Recipient, the Recipient's authorized representative (if applicable) and the** referrer within three business days of a decision. If not eligible, Contractor shall provide an explanation of the decision and information on how to request reconsideration or to appeal the decision. Contractor shall include instructions on next steps.

Contractor shall conduct eligibility redeterminations ~~at least~~ every 12 months for each Recipient using the standards defined in this Contract. **Medical Appropriateness determinations and re-determinations of 1915(i) HCBS Home Based Habilitation and HCBS Behavioral Habilitation services are based on the Recipient's ongoing 1915(i) program eligibility and assessment of need for 1915(i) HCBS, regardless of the HCBS setting in which Recipient resides. Re-authorizations for 1915(i) HCBS Home Based Habilitation and HCBS Behavioral Habilitation services are valid for the duration of the Recipient's annual person-centered service plan. If a service is medically appropriate per the process outlined in this Contract and OAR 410-172-0630, OAR 410-120-0000(135)(b), and OAR 410-120-0000(146)(d) and (e), then it is Prior Authorized per OAR 410-172-0650.**

Contractor shall complete eligibility redeterminations within the same time frames as noted above for initial determinations.

Contractor shall conduct internal quality and process reviews of eligibility determinations to ensure the level of scrutiny is consistent and monitored; including review of the original determination and any redeterminations using new information provided by the referrer.

Contractor shall refer requests for appeal of the eligibility determination to OHA **within one business day.** OHA manages the appeal process and notifies the requester of the outcome of the appeal. OHA has the final determination of eligibility under the appeal process described in Oregon Administrative Rule.

Contractor shall collect and report data for the 1915(i) quality assurance report. Data must be reported quarterly and shall include:

(i) Total number of evaluations conducted during the quarter.
(ii) Total number of evaluations that meet HCBS eligibility criteria during the quarter.
(iii) Total number of evaluations that were appealed.
(iv) Total number of participants due for an annual redetermination.
(v) Total number of service plans that were adequate and appropriate to assessed need.
(vi) Total number of service plans that address participants' personal goals,
(vii) Total number of service plans that meet requirements of appropriate staff.
(viii) Total number of service plans that reflect involvement of participant.
(ix) Total number of service plans that include measurable and observable intended outcomes.
(x) Total number of service plans that were reviewed and revised based on changing needs.
(xi) Total number of service plans that were revised within 12 months of their last evaluation when services continued for more than 12 months.
(xii) Percent of participants records who received the type, scope, amount, duration and frequency of services specified in the service plan.
(xii) Total number of records reviewed that demonstrated participant involvement in service plan development.

d. Medical Appropriateness Review services shall be effective July 1, 2016.

Contractor shall conduct Medical Appropriateness Reviews ~~to ensure the level of care and the type of service provided to Recipients of fee-for-service and OHA-~~

~~funded behavioral health services are medically appropriate as described in OAR 410-172-0600~~ **of 1915(i) HCBS simultaneously with program eligibility and re-eligibility as follows**:

(1) Initial Reviews: Medical Appropriateness for 1915(i) HCBS are based upon the Recipient's need for the services as identified in the functional needs assessment and documented in the Recipient's annual person-centered service plan, regardless of the HCBS setting in which Recipient resides. A qualified mental health professional shall review the request according to OAR 410-172-0630, OAR 410-120-0000(146)(d) and the following:

(a) Medical Appropriateness of HCBS Home Based Habilitation and HCBS Behavioral Habilitation services is based on the Recipient's ongoing 1915(i) program eligibility and assessment of need of 1915(i) HCBS. Authorizations for these habilitation services are valid for the duration of the Recipient's annual person-centered service plan. This means that the periodic utilization review period is annual unless the Recipient's circumstances or needs change significantly, or at the request of the Recipient. Otherwise, Contractor shall not conduct more frequent periodic medical appropriateness reviews of 1915(i) HCBS Home Based Habilitation and 1915(i) HCBS Behavioral Habilitation.

(b) Medical Appropriateness of 1915(i) HCBS Psychosocial Rehabilitation Services for persons with Chronic Mental Illness as defined in OAR 410-172-0700, is based on the Recipient's ongoing 1915(i) program eligibility, and assessment of Recipient's needs. 1915(i) HCBS Psychosocial Rehabilitation Services for persons with Chronic Mental Illness as defined in OAR 410-172-0700, are valid for as long as they are deemed medically appropriate by a qualified mental health professional.

(c) If a service is medically appropriate per the process outlined in this Contract and OAR 410-172-0630, it is Prior Authorized per OAR 410-172-0650.

(d) This process should be completed within 10 business days of receiving the request. Once complete, Contractor shall provide the completed review to the MMIS technical staff.

(2) Subsequent Medical Appropriateness Reviews:

For 1915(i) HCBS, medical appropriateness reviews of provided services are assessed regardless of the HCBS setting in which Recipient resides and occur at the time of eligibility re-determination, which is annually unless the Recipient's circumstances or needs

change significantly, or at the request of the Recipient. Reviews must also consider OAR 410-120-0000(146)(d).

(a) Reviews of medical appropriateness of HCBS Home Based Habilitation and HCBS Behavioral Habilitation are based on the Recipient's ongoing 1915(i) program eligibility and assessment of need of 1915(i) HCBS. Re-authorizations for 1915(i) HCBS Home Based Habilitation and 1915(i) HCBS Behavioral Habilitation services are valid for the duration of the Recipient's annual person-centered service plan.

(b) Review of medical appropriateness of 1915(i) HCBS Psychosocial Rehabilitation Services for persons with Chronic Mental Illness as defined in OAR 410-172-0700, is based on the Recipient's ongoing 1915(i) program eligibility, and assessment of Recipient's needs. Recipient's HCBS setting is not contingent upon or affected by the Recipient's receipt of HCBS Psychosocial Rehabilitation Services for persons with Chronic Mental Illness as defined in OAR 410-172-0700. For this service, periodic utilization review periods may be more frequent than annually.

(c) If a service is medically appropriate per the process outlined in this Contract and OAR 410-172-0630, then it is deemed Prior Authorized per OAR 410-172-0650.

(d) This process should be completed within 10 business days of receiving the request. Once complete, the completed review is given to the MMIS technical staff.

e. Transition Planning for 1915(i) eligible Recipients.

- **Transition management and planning for Recipients arises when transitioning among HCBS settings based on Recipient's choice of provider or desire to reside in a non-licensed setting (such as their own residence).**
- **Contractor's transition plans may include referral to licensed settings, recommendations for non-Medicaid services and supports, or the need for specialized services or funding, working with county mental health agencies and/or Choice Providers.**

f. Conflict Free Case Management services.

Conflict Free Case Management services shall be effective October 1, 2016.

~~(1) Contractor shall provide conflict free case management for the following member populations:~~

~~(a) Medicaid eligible individuals who are fee-for-service and who need assistance accessing behavioral health services.~~

~~(b) Individuals residing at Oregon State Hospital (OSH) who have been determined as ready to transition.~~

~~(c) Fee-for-service members who are currently residing in an OHA funded SRTF and have been determined to no longer need that setting in order to receive services and supports.~~

~~(2)~~ **(1)** Contractor shall perform the functions of conflict free case management for the following purposes:

(a) Service and Support Planning. ~~Contractor shall engage in processes that lead to a service or support plan~~. Under CMS rules, **Contractor shall engage in processes consistent with the person-centered approach and** these processes ~~must be consistent with the person-centered approach and~~ must include an independent needs assessment resulting in a documented **person-centered service plan created by the Contractor** ~~plan of care~~.

(b) Monitoring. Contractor shall engage in processes for ensuring that services are delivered according to guidance included in the **person-centered service** ~~support~~ plan ~~(hospital-to-community transition plan or community transition plan)~~. Activities may include coordinating services, monitoring the quality of services, monitoring the ~~participant~~**Recipient**, and reporting compliance of ~~contracted entities~~ **parties** responsible for implementing the **person-centered service** ~~support~~ plan.

(c) Supporting services to be provided in the ~~most integrated~~ **HCBS** setting ~~appropriate to the needs of~~ **chosen by** the ~~individual~~ **Recipient**.

(d) Independent Needs Assessment. Contractor shall conduct an independent functional needs assessment in accordance with Oregon's 1915(i) HCBS SPA and 42 CFR 441.720.

~~(e) For member populations residing at the Oregon State Hospital, or in secure residential treatment programs, Contractor shall achieve the performance metrics described in Exhibit F, Attachment 4 – IQA Rates and Metric and Performance Tables.~~

~~(3) Standard for Completed Work. For each person transitioned from an SRTF to an HCBS setting, a written person-centered services and supports plan, will be developed by the Contractor.~~

~~(4)~~ **(2) For Recipients choosing to transition amongst HCBS settings,** ~~t~~The **person-centered service** ~~plan of care~~ will be provided **by the Contractor** to the contracted community entity responsible for the coordination of care for the ~~person~~ **Recipient** prior to transition, considerate of the time necessary to implement the plan.

~~(5)~~ **(3) For Recipients losing 1915(i) HCBS eligibility**, Contractor's transition plans may include referral to licensed settings, recommendations for non-

Medicaid services and supports, or the need for specialized services or funding.

~~(6)~~ **(4)** Contractor shall coordinate the implementation of the **person-centered service** plan ~~of care~~ for **Recipients** who do not have support or assistance from a **contracted community entity**~~community organization~~.

~~g. Treatment Episode Monitoring shall be implemented as required to serve the Recipients.~~

~~(1) For OHA funded, fee for service and/or 1915(i) HCBS individuals authorized by the Contractor, Contractor will conduct self-defined periodic review of approved services to determine the authorized service is provided in accordance with applicable Oregon Administrative Rules and the service meets the criteria for quality and medical appropriateness.~~

~~(2) For OHA funded, fee for service and/or 1915(i) HCBS individuals authorized by the Contractor, Contractor shall determine type and frequency of review based on the type of service and authorization parameters. Reviews shall be conducted through onsite visit, face to face interview of Recipient or provider, document review, clinical documentation review or data analysis.~~

~~(3) Treatment episode monitoring may include administration or review of standardized assessments or tools determined by the contractor.~~

~~Concurrent review of need for inpatient care.~~

- ~~For recipient groups to be determined by OHA, contractor shall provide prospective and/or concurrent review by a physician, physician assistant, or nurse practitioner for the purpose of ensuring the medical appropriateness of inpatient services funded by OHA or for which Oregon claims federal medical assistance payments. Certification must be provided by a physician, or physician assistant or nurse practitioner acting within the scope of practice as defined by State law.~~
- ~~Member Recipient groups and initial review and periods of authorization and re-review will be based on OHA's business or regulatory needs.~~
- ~~Certification and re-certification shall be based upon~~
- ~~Proper treatment of the psychiatric condition requires services on an inpatient basis under the direction of a physician; and~~
- ~~The services can reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed.~~
- ~~For individuals with SPMI at OSH under civil commitment or voluntary by guardian:~~
    - ~~for more than 90 days, the contractor shall perform a clinical~~

~~review of the individual's status to determine whether a continued stay at OSH is necessary.~~

- ~~When a review is performed, the justification for the individual's stay shall be clearly documented.~~
- ~~If the contractor determines that there is an appropriate clinical justification for the individual to remain at OSH, the contractor shall approve the extension of the individual's stay for up to 45 additional days.~~
  - ~~If an extension has been approved, the contractor shall conduct a follow-up clinical review of the individual's status every additional 45 days.~~
- ~~If the contractor determines that there is not an appropriate clinical justification for the individual to remain at OSH, contractor shall immediately notify OSH of the determination.~~

~~(4) For each treatment episode monitoring service invoiced to OHA, Contractor shall provide OHA a treatment episode monitoring detail report describing the reason for the review, the type of review, and the outcome of the review. OHA will not issue payment for these services until this condition is met.~~

g. Census Reporting shall be effective October 1, 2016.

Contractor shall develop and provide an ongoing accessible report containing information about fee-for-service members currently in a licensed residential settings **or their own home**, including:

(1) Member name,
(2) Member Medicaid number,
(3) Member age,
(4) Primary diagnosis,
(5) County of responsibility,
(6) Referral source, such as OSH, acute care, post-acute intermediate treatment, licensed care, or the community,
(7) Managed care enrollment status (Enrolled or FFS),
(8) ~~Level of Care~~ **Type of settings** (AFH, RTF, RTH, **SRTF, in-home, etc.**),
(9) First or previous assessment score,
(10) Second or **later** assessment score,
(11) Current assessment score,
(12) Name of current provider,
(13) Date of admission,
(14) Length of stay for current treatment episode, **and**
(15) Whether **1915(i)**-plan eligible (Y/N)**.**
~~(16) Expiration of 1915(i) plan eligibility.~~

OHA must be able to access a report containing the required information listed above. The information will be accurate to the information provided to Contractor. OHA will not issue payment for these services until this condition is met.

h. The Independent and Qualified Agency rates and metrics and performance expectations are contained in Exhibit F, Attachment 4 – ~~IQA~~ Rates and Metric and Performance Tables.

8. SRTF and OSH service review and transition planning (specific to the non-1915(i) eligible population):

a. Contractor shall conduct Medical Appropriateness Reviews to ensure the level of care and the type of service provided to Recipients of fee-for-service and OHA funded behavioral health services are medically appropriate as described in OAR 410-172-0600 through 410-172-0860.

i. Medical appropriateness reviews requiring prior authorization shall be completed in accordance with the requirements described in exhibit A, Part 2, Section 4, subsection e.

ii. Medical appropriateness reviews for referral to, admission and continued stay in Secure Residential Treatment Facilities (SRTF) shall be made in accordance with OAR 410-172-0720(7). This process should be completed within 10 business days of receiving request. Once the review is complete, materials relied on to make the determination along with the recommendation to approve or deny must be sent to OHA for final determination.

b. Contractor shall provide technical assistance, monitoring and reporting to OHA regarding hospital-to-community transition plan implementation and outcomes.

i. Contractor shall perform the functions of conflict free case management for the following purposes:

The plans-of-care for individuals residing at Oregon State Hospital, who have been determined as ready to transition, shall be referred to as the hospital-to-community transition plans and must include a level of care recommendation. The plans-of-care for **non-1915(i) eligible** fee-for-service members, who are currently residing in an OHA funded licensed ~~**level of care**~~ **residential setting** and have been determined to no longer need that setting in order to receive services and supports, shall be referred to as the community transition plan.

ii. Standard for Completed Work. For each person transitioned from OSH or SRTF, a hospital-to-community transition plan or a community transition plan, in the form of a written person-centered services and supports plan, will be developed by the Contractor.

(1) Contractor must develop a written person-centered services and supports plan after a face-to-face assessment of the

individual and using a person-centered process that is guided by best practice and research on effective strategies that result in improved health and quality of life outcomes.

(A) The individual receives appropriate support during the assessment, including the use of any necessary on-site support-staff.

(B) The individual provides informed consent for this type of assessment.

(2) Contractor must conduct the assessment in consultation with the individual, and if applicable, the individual's authorized representative, and include the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals responsible for the individual's care. If the individual refuses the participation of others, this shall be documented.

(3) Contractor must examine the individual's relevant history including the findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the person-centered service plan.

(4) Contractor must include in the assessment the individual's physical, cognitive, and behavioral health care and support needs, strengths and preferences, available service and housing options, and if unpaid caregivers will be relied upon to implement any elements of the person-centered service plan, a caregiver assessment.

iii. Contractor's transition plans may include referral to licensed settings, recommendations for non-Medicaid services and supports, or the need for specialized services or funding.

c. Conflict Free Case Management services for non-1915(i) HCBS Recipients.

Conflict Free Case Management services shall be effective October 1, 2016.

(1) Contractor shall provide conflict free case management for the following member populations:

(a) Medicaid eligible individuals who are fee-for-service and who need assistance accessing behavioral health services.

(b) Individuals residing at Oregon State Hospital (OSH) who have been determined as ready to transition.

(c) Fee-for-service members who are currently residing in an OHA funded SRTF and have been determined to no longer need that setting in order to receive services and supports.

(2) Contractor shall perform the functions of conflict free case management for the following purposes:

(a) Service and Support Planning. Contractor shall engage in processes that lead to a service or support plan. Under CMS rules, these processes must be consistent with the person-centered approach and must include an independent **face-to-face** needs assessment resulting in a documented plan of care.

(b) Monitoring. Contractor shall engage in processes for ensuring that services are delivered in according to guidance included in the **service and** support plan (hospital-to-community transition plan or community transition plan). Activities may include coordinating services, monitoring the quality of services, monitoring the participant, and reporting compliance of contracted entities responsible for implementing the support plan.

(c) Supporting services to be provided in the most integrated setting appropriate to the needs of the individual.

(d) For member populations residing at the Oregon State Hospital, or in secure residential treatment programs, Contractor shall achieve the performance metrics described in Exhibit F, Attachment 4 – ~~IQA~~ Rates and Metric and Performance Tables.

(3) Standard for Completed Work. For each person transitioned from an SRTF to an HCBS setting, a written person-centered services and supports plan, will be developed by the Contractor.

(4) The plan-of-care will be provided to the contracted community entity responsible for the coordination of care for the person prior to transition, considerate of the time necessary to implement the plan.

(5) Contractor's transition plans may include referral to licensed settings, recommendations for non-Medicaid services and supports, or the need for specialized services or funding.

(6) Contractor shall coordinate the implementation of the plan-of-care for individuals who do not have support or assistance from a community organization.

d. Treatment Episode Monitoring shall be implemented as required to serve the Recipients.

(1) For OHA-funded, fee for service ~~and/or 1915(i) HCBS~~ individuals authorized by the Contractor, Contractor will conduct self-defined periodic review of approved services to determine the authorized service is provided in accordance with applicable Oregon Administrative Rules and the service meets the criteria for quality and medical appropriateness.

(2) For OHA-funded, fee for service ~~and/or 1915(i) HCBS~~ individuals authorized by the Contractor, Contractor shall determine type and

frequency of review based on the type of service and authorization parameters. Reviews shall be conducted through onsite visit, face to face interview of Recipient or provider, document review, clinical documentation review or data analysis. **With each invoice, Contractor shall certify that Treatment Episode Monitoring has the purpose of ensuring that services billed for actually occurred, and is not duplicative of Contractors' services invoiced for medical appropriateness review or Prior Authorization.**

(3) Treatment episode monitoring may include administration or review of standardized assessments or tools determined by the contractor.

Concurrent review of need for inpatient care.

- For recipient groups to be determined by OHA, contractor shall provide prospective and/or concurrent review by a physician, physician assistant, or nurse practitioner for the purpose of ensuring the medical appropriateness of inpatient services funded by OHA or for which Oregon claims federal medical assistance payments. Certification must be provided by a physician, ~~or~~ physician assistant or nurse practitioner acting within the scope of practice as defined by State law.
- ~~Member~~ Recipient groups and initial review and periods of authorization and re-review will be based on OHA's business or regulatory needs.
- Certification and re-certification shall be based upon:
    - Proper treatment of the psychiatric condition requires services on an inpatient basis under the direction of a physician; and
    - The services can reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed.
- For individuals with SPMI at OSH under civil commitment or voluntary by guardian:
    - for more than 90 days, the contractor shall perform a clinical review of the individual's status to determine whether a continued stay at OSH is necessary.
        - When a review is performed, the justification for the individual's stay shall be clearly documented.
        - If the contractor determines that there is an appropriate clinical justification for the individual to remain at OSH, the contractor shall approve the extension of the individual's stay for up to 45 additional days.
            - If an extension has been approved, the contractor shall conduct a follow-up clinical

review of the individual's status every additional 45 days.

- If the contractor determines that there is not an appropriate clinical justification for the individual to remain at OSH, contractor shall immediately notify OSH of the determination.

(4) For each treatment episode monitoring service invoiced to OHA, Contractor shall provide OHA a treatment episode monitoring detail report describing the reason for the review, the type of review, and the outcome of the review. OHA will not issue payment for these services until this condition is met.

e. Census Reporting shall be effective October 1, 2016.

Contractor shall develop and provide an ongoing accessible report containing information about fee-for-service members currently in a licensed **setting or their own home** ~~level of care~~, including:

(1) Member name,
(2) Member Medicaid number,
(3) Member age,
(4) Primary diagnosis,
(5) County of responsibility,
(6) Referral source, such as OSH, acute care, post-acute intermediate treatment, licensed care, or the community,
(7) Managed care enrollment status (Enrolled or FFS),
(8) **Type of settings (AFH, RTF, RTH, SRTF, in-home, etc.)**~~,Level of care (AFH, SRTF etc.),~~
(9) First or previous assessment score,
(10) Second or **later** assessment score,
(12) Current assessment score,
(13) Name of current provider,
(14) Date of admission,
(15) Length of stay for current treatment episode,
(16) Whether **1915**(i)-plan eligible (Y/N), and
(17) ~~Expiration of **1915**(i) plan eligibility.~~

OHA must be able to access a report containing the required information listed above. The information will be accurate to the information provided to Contractor. OHA will not issue payment for these services until this condition is met.

f. The Independent and Qualified Agency rates and metrics and performance expectations are contained in Exhibit F, Attachment 4 – ~~IQA~~ Rates and Metric and Performance Tables.

9. Outreach and Engagement.

a. Contractor shall contact all new high risk, high acuity and moderate risk, moderate acuity FFS Clients within 30 calendar days of receipt of the monthly claims data from OHA. This 30-day outreach requirement must include FFS Clients who stratify as acuity levels of four or five.

b. Contractor shall contact all new FFS Clients with lower risk and acuity within 60 calendar days of receipt of the monthly claims data from OHA. This 60-day outreach requirement must include FFS Clients who stratify as acuity levels of one, two, or three.

c. Contractor shall document, in Contractor's FFS Client Management System, new FFS Clients, who have been successfully contacted by the Contractor and who consent to participate in the Program and to receive Program services. A successful contact, or engagement, may be accomplished when the Contractor makes telephone contact with the FFS Client and the FFS Client orally agrees to receive Program services.

d. Contractor shall attempt to contact the FFS Client by telephone on three separate days and times over the applicable 30-day or 60-day required period as described in subsections a. and b. above. If the three telephone attempts are unsuccessful, Contractor shall attempt to engage the FFS Client using alternative outreach methods, such as mailing a request for the FFS Client to contact Contractor or contacting the FFS Client in person or face-to-face.

e. Contractor shall have a process to document its attempts to contact the FFS Client, any follow-up attempts, and the results of the attempts. Contractor shall use this documentation to determine the most successful methods to engage FFS Clients and to recommend changes to OHA.

f. Contractor shall not make further attempts to engage a FFS Client:

(1) Who fails to respond to the telephone and other contact attempts as described in subsection d. above.

(2) Whose mail is returned "unable to deliver" with no forwarding information.

(3) Who does not meet the criteria for an acuity score as determined by Contractor's health stratification and risk assessment processes.

(4) Who has opted-out of the Contractor's Program for Care Coordination and other services.

(5) Who, when contacted, is determined to be not eligible for Contractor's Program.

g. Notwithstanding subsection f. above, Contractor shall attempt to locate and engage FFS Clients in person in healthcare provider offices, clinics, hospitals, or other community locations:

(1) When the Program eligible FFS Client remains within the high risk, high acuity level or at risk for utilization for greater than 90 calendar days and has failed to respond to other contact attempts.

(2) When the Program eligible FFS Client remains within the high risk, high acuity level or at risk for utilization for greater than 90 days and has no active telephone number on file.

h. Contractor shall suspend FFS Clients from its client engagement process when all attempts to contact and locate the FFS Client as described in this Section have been unsuccessful. Contractor shall document in its FFS Client Management System those FFS Clients suspended from its client engagement process. Contractor shall continue to provide NAL services to FFS Clients who have been suspended from its client engagement process. Contractor shall not deny FFS Clients future enrollment in the Program due to a suspension of the engagement process.

i. FFS Clients may opt-out of the Contractor's Program during the engagement process. FFS Clients who opt-out of the Program and remain on OHP fee-for-service status may receive Oregon Health Plan Care Coordination (OHPCC) services at any time.

j. Outreach Communications.

Contractor shall ensure all outreach communications with FFS Clients:

(1) Are culturally and linguistically appropriate;

(2) Are provided in a manner or format easily understood by FFS Client;

(3) Indicate the toll-free telephone number for Contractor's Program of healthcare services; and

(4) Include the Contractor's Program name, contact information, and web-site address.

k. Outreach for Program Enrolled FFS Clients.

(1) Initial Outreach Package.

(a) Contractor shall provide an initiation or initial welcome outreach package to all FFS Clients newly enrolled in Contractor's Program. Contractor's outreach package must, at a minimum:

i. Include information about the FFS Client's enrollment in the Program.

ii. Inform the FFS Client that enrollment is part of the Client's Medicaid benefit and that the Program is provided at no cost to Client.

iii. Introduce the Program services available to the FFS Client.

iv. Include information about Care Coordination, Disease Management and Intensive Care Management, and the NAL.

v. Include a copy of the Client's Rights and Responsibilities as described in Exhibit F of this Contract.

vi. Notify the FFS Client that participation in the Program is by choice and that the FFS Client retains the right to opt out of the Program at any time.

Contractor will provide the initial welcome outreach package to the Program enrolled Clients within 30 calendar days of notification of the Client's enrollment.

(2) Contractor shall include ongoing education and instruction in its outreach to FFS Clients. Contractor's education and instruction shall include the following topics:

(a) Self-care skills and assistance with securing supportive resources.

(b) Education and coaching on tobacco cessation and avoidance of second hand smoke.

(c) Education and assistance on the elimination of barriers to care.

(d) Education and coaching on the use of medical and community resources, in support of a PCPCH and the FFS Client's health conditions.

(e) Education and coaching about medication management.

l. Contractor shall schedule regular visits to high volume or high utilization Medicaid fee-for-service hospitals and emergency departments and federally qualified health centers, with a goal of minimizing inappropriate FFS Client visits and reducing both admissions for the same condition and lengths of stays.

m. Contractor shall work with healthcare providers, stakeholder groups, OHA and DHS-APD to promote participation and enrollment in Contractor's Program and to maximize knowledge and utilization of existing resources.

(1) Contractor shall establish working relationships, partnerships, or collaborations with other OHA divisions, other State agencies, and profit and non-profit organizations as these relationships, partnerships, or collaborations relate to FFS Clients.

(2) Contractor shall support the activities of other OHA divisions, other State agencies, and profit and non-profit organizations as the activities relate to FFS Clients.

(3) Contractor shall incorporate into its Program access or referral to, or utilization of, existing resources available from other OHA divisions, State agencies, or profit and non-profit organizations when appropriate to the Program and to the benefit of FFS Clients.

(4) Contractor shall facilitate communication to address primary healthcare issues, clinical or social services alerts, identified gaps in care, and

increased utilization related to FFS Clients' assessed and self-reported needs.

(5) In collaboration with OHA, Contractor shall utilize OHA's Pharmacy Clinical Services contractor for consultation in the areas of Drug Use Review, Preferred Drug List development and maintenance, drug use policy and evaluation of drug therapy.

n. Contractor shall maintain a Clinical Advisory Committee (CAC). The purpose of the CAC is to establish an ongoing positive relationship with the healthcare community and to maintain a consistently high-level of communication with stakeholders. The CAC shall consist of key stakeholders, chosen by Contractor and approved by OHA, that meets twice per calendar year, or as mutually agreed upon by the Contractor and OHA. OHA shall provide a representative for the CAC who shall participate as a stakeholder on the committee.

10. Enrollment.

a. FFS Clients enrolled in the OHP, who are included within the eligibility files received by Contractor from OHA, are eligible for enrollment in the Contractor's Program and for Contractor's services. Clients may enroll in Contractor's Program either by telephone or mail correspondence or in person agreement as described in this Contract. Participation in the Contractor's Program will not affect the FFS Client's OHP benefit plan. Program eligible Clients, who choose not to participate at the time of initial contact by the Contractor, will remain eligible to participate, as defined in this Contract, at any future time.

b. Enrollment in the Contractor's Program by the FFS Client is voluntary. Contractor shall permit FFS Clients to opt-out of the Program at any time.

c. FFS Clients have the right to change their assigned registered nurse or primary care manager. A Program enrolled Client may change their assigned registered nurse or primary care manager using an oral or written request submitted to the FFS Client's current registered nurse or primary care manager, an OHA or DHS-APD supervisor.

d. Contractor may assign a new registered nurse or primary care manager to a FFS Client when there is a change in the FFS Client's acuity level. Generally, registered nurses or primary care managers based in the community will manage care for the higher acuity FFS Clients while lower acuity FFS Clients can be managed telephonically by a disease management coordinator.

e. Contractor shall not remove a Program enrolled Client from the Program based upon a negative change in the FFS Client's health status, utilization of medical services, or diminished mental capacity.

f. Contractor shall not remove a FFS Client from the Program due to uncooperative or disruptive behavior resulting from the FFS Client's special needs, except when that FFS Client's behavior and continued enrollment in the Program impairs the ability or safety of Contractor to provide services to the FFS Client. Contractor's removal of a FFS Client from the Program under these circumstances shall be immediately communicated to the OHA OHPCC Contract Administrator.

g. Contractor shall notify the FFS Client's primary care provider of the Client's enrollment in the Program.

11. Disenrollment.

a. Contractor shall discontinue efforts to contact or locate Program eligible Clients when the attempts have failed, as described in Section 9 Enrollment. FFS Clients not enrolled in Contractor's Program services will continue to receive the benefits of the Contractor's NAL and may be contacted by Contractor at a later date for possible enrollment in the Program.

b. Contractor may disenroll a FFS Client from the Contractor's Program when the FFS Client moves out of Oregon.

c. Contractor shall not disenroll a FFS Client due to uncooperative or disruptive behavior resulting from his or her special needs, except when that FFS Client's behavior and continued enrollment in the Program impairs the ability or safety of Contractor to provide the Program services to the FFS Client.

d. Contractor shall immediately communicate to the OHA OHPCC Contract Administrator when Contractor disenrolls a FFS Client. Contractor's disenrollment decision is subject to OHA review upon Client's request. Regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which Contractor notified OHA.

e. Contractor shall advise the disenrolled FFS Client of Client's rights to appeal disenrollment from Contractor's Program to OHA.

12. Marketing and Communications.

a. General Provisions.

(1) All forms of Contractor's communications must meet the language requirements identified in this Section and be culturally and linguistically sensitive to FFS Clients with disabilities or reading limitations, including FFS Clients whose primary language is not English.

(2) OHA and DHS-APD shall approve, prior to distribution, any communication related to outreach, health promotion, and health education produced by Contractor, or Subcontractors, that is intended solely for FFS Clients and pertains to the Program services and benefits.

(3) OHA and DHS-APD will provide Contractor with the current logo or signature for a specific communication only when OHA, DHS-APD, and Contractor have determined the logo or signature is necessary for a particular document produced by Contractor for Program marketing and communications. OHA and DHS-APD will notify Contractor when there are changes to the logos.

(4) Contractor shall address any health literacy issues by preparing the communications at a 6th grade reading level, incorporating graphics when appropriate, using a 12-point font or larger, and utilizing alternate formats.

(5) Contractor shall make communications available in alternate formats for presentation to FFS Clients with disabilities. Standard alternate formats include Braille, large (18-point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide.

(6) Contractor shall consult with OHA's Office of Equity and Inclusion for information on communication methods that are culturally specific and culturally competent.

b. Written Communications.

(1) Contractor shall develop the following written communications as needed to assist FFS Clients in understanding the requirements and benefits of the Program:

(a) Marketing brochures, pamphlets, newsletters, posters and fliers,

(b) Educational or instructional materials,

(c) Enrollment notices, and

(d) Informational materials.

(2) Contractor shall accommodate requests from OHA to translate written communications into the prevalent non-English language for the FFS Client.

(3) Contractor shall notify FFS Clients that written communication is available in alternate formats and how to access those formats.

(4) Contractor shall obtain OHA and DHS-APD approval to any changes in written communication to FFS Clients at least 30 calendar days prior to the effective date of the change.

c. Electronic Media.

(1) Contractor shall electronically provide to OHA for approval each version of the printed outreach package described in Section 8 Outreach and Engagement.

(2) At least 30 calendar days prior to use, Contractor shall provide to OHA for approval all website and web-based publications related to Contractor's Program.

d. Interpretation and Translation.

(1) Contractor shall provide certified, healthcare interpretation services free of charge to non-English speaking FFS Clients and their family members. Oral interpretation services apply to all non-English languages, not just prevalent non-English languages.

(2) Contractor shall translate written communications into the prevalent non-English language of the FFS Client and family members or caregivers when needed by the FFS Client.

(3) Contractor shall notify FFS Clients that interpretation and translation services are available and how to access the services.

e. Limitations for Marketing and Communications.

(1) Contractor shall not engage in door-to-door, telephone, or any cold-call marketing activities, promotions, or solicitations for any purpose beyond what is specified within the terms of this Contract, or as mutually agreed upon by OHA and Contractor for the benefit of Program eligible, FFS Clients.

(2) Contractor shall not contact FFS Clients at any time for reasons other than those described in this Contract without OHA's prior written approval.

(3) Contractor shall not make any assertion or statement, whether written or oral, that Contractor is endorsed by CMS, the federal or State government, or any other similar entity.

(4) Contractor shall not make any assertion or statement, whether written or oral, that the FFS Client must enroll in the Contractor's Program in order to obtain or maintain Oregon Health Plan benefits.

13. Evaluation; Quality Control and Process Improvement.

a. Contractor shall have written Quality Control and Process Improvement programs applicable to the Program. Contractor shall:

(1) Ensure its Quality Control and Process Improvement programs are implemented and maintained.

(2) Make its Quality Control and Process Improvement programs available to OHA when requested.

(3) Develop and maintain a Quality Control and Process Improvement system for the management and resolution of FFS Client and healthcare provider complaints, grievances, and compliments.

(4) Have Process Improvement or Quality Control strategies and measures that demonstrate the monitoring and evaluation of FFS Client satisfaction.

(5) Perform Quality Control and Process Improvement to identify Program service gaps and barriers to care, and implement corrective actions.

(6) Contractor shall develop and implement a minimum of one Quality Control or Process Improvement initiative per fiscal year that must be mutually agreed to by Contractor and OHA.

b. Contractor shall measure and report to OHA its Program equality related to health and cultural competency.

c. Contractor shall monitor Health Literacy to demonstrate improvement in FFS Client's participatory management skills.

d. Contractor shall provide direct supervision and performance management of its personnel using interpersonal and electronic processes including, but not limited to:

(1) Productivity and performance goals based upon position and key responsibilities.

(2) Comparative productivity relative to similar professional staffing or positions.

(3) Core staff behaviors such as attendance and punctuality.

(4) Random review of plans-of-care and interventions.

(5) Random silent monitoring of primary care managers and Disease Management and Intensive Care Management staff telephone calls on at least a quarterly timeframe.

(6) Discussion with community liaisons or supervisors in clinical facilities who have contact with Contractor's staff.

e. Contractor shall have documented systems and processes to monitor and ensure the quality of the Program's operation. Contractor's systems and processes must, at a minimum, include:

(1) Silent monitoring of Care Coordination, Disease Management, Intensive Care Management, and NAL staff telephone calls on a random basis.

(2) Telephonic monthly metrics reports including:

(a) Average time to answer or average speed of answer (ASA),

(b) Average call duration,

(c) Average duration on hold,

(d) Number of outgoing calls,

(e) Number of incoming calls, and

(f) Number of transferred calls.

f. Outcome Measurement

(1) Contractor shall perform critical analysis for evaluation of Contractor's Program.

(a) Contractor shall work with OHA to:

i. Establish mutually agreed upon baselines for results comparison.

ii. Monitor the expected clinical outcomes through claims data activity analysis.

iii. Establish targeted improvement on clinical outcomes.

(b) Contractor shall measure the degree of improvement from the baseline to the clinical outcome at the end of each 12-month service cycle.

(2) Contractor's health outcome measurements shall be aligned with the metrics utilized by the CCOs and required by OHA. Contractor shall

evaluate and report the effectiveness and efficiency of Contractor's Program in meeting the applicable State health outcome metrics. The metrics can be found at http://www.oregon.gov/oha/Pages/metrix.aspx.

(3) Contractor shall use national and OHA metrics established for State Healthcare Outcomes Reform as the basis to determine mutually agreed upon measurements for the Program that include, but are not limited to, the following components:

(a) Evidence-based practices and strategies that improve health outcomes.

(b) Strategies and interventions to reduce medical costs.

(c) Reduction in hospitalization of ambulatory care sensitive conditions.

(d) Reduction in non-emergent utilization of emergency departments.

(e) Reduction in tobacco and chemical dependency.

(f) Reduction in under-immunized children and adults.

(g) Reduction in health and racial disparities.

(h) Cost effective Care Coordination, Disease Management, and Intensive Care Management services within OHP Medicaid parameters.

(i) Use of strategies and interventions that reduce or prevent the progression of chronic conditions or acute catastrophic events.

(j) Reduction in barriers to access and care from both the healthcare provider and FFS Client.

(k) Increase in the number of FFS Clients with a medical home.

14. Data, Records, and Reports.

a. Contractor shall create, prepare, and share documentation, data, metrics, and reports with OHA and DHS-APD for the following: Care Coordination Pre-management, Independent and Qualified Agent, Care Coordination, Disease Management, Intensive Care Management, and the NAL.

b. Contractor shall prepare and submit all data and documents in a format acceptable to OHA. Records, data, or reports submitted to OHA shall be revised and resubmitted as requested by OHA to OHA's satisfaction. OHA shall notify Contractor of the need to revise the contents of the records, data, or reports within seven calendar days of its receipt. OHA shall specify, in its written request to revise the contents, a length of time for Contractor to correct the unsatisfactory information.

c. Contractor and OHA agree that an electronic solution is needed for sharing and posting reports and data files. The parties shall collaboratively work toward a solution.

d. Contractor shall prepare and submit to OHA written Care Coordination and Independent and Qualified Agent status reports monthly, with the content and format agreed to by OHA and DHS-APD.

e. Contractor will document all NAL interactions and report the interactions monthly to the OHA OHPCC Contract Administrator. These metrics reports will include, but are not limited to, the number and nature of calls, types of interventions offered, referrals made, and resolution of calls.

f. Contractor shall prepare and submit to the OHA OHPCC Contract Administrator an annual written evaluation report of Program services performed.

g. Contractor shall prepare and submit annual and quarterly reports to the Health Systems Division leadership.

h. Contractor shall have access to OHA and DHS-APD FFS Client records and data applicable to the performance of its Work under this Contract.

i. Contractor shall ensure that FFS Clients may request and receive a copy of his or her records generated by the Contractor and has the right to request that they be amended or corrected as specified in 45CFR Part 164.

j. OHA shall advise Contractor of the name and the physical address or email address of the recipient(s) of the data, records, and reports.

k. Contractor shall prepare and submit written quarterly Program reports including but not limited to:

(1) Total case load;

(2) Number, percentage and type of completed assessments;

(3) Number, percentage, and type of incomplete assessments;

(4) Number and type of interventions and follow-up activities;

(5) Number of FFS Client complaints, concerns, resolutions, and compliments;

(6) Number of provider complaints, concerns, resolutions and compliments;

l. Report Delivery Schedule.

(1) Weekly and monthly Program status update reports shall be delivered to OHA by the last business day of the week and month following the end of the subject week and month respectively. These weekly and monthly reports must be delivered using an application such as SharePoint®.

(2) Quarterly Program status update reports shall be delivered to OHA no later than 45 calendar days after the end of the previous quarter. Quarters are defined by the State's fiscal year as July 1 to September 30, October 1 to December 31, January 1 to March 31, and April 1 to June 30.

(3) Annual Program reports shall be delivered to OHA within 90 calendar days of the end of the previous fiscal year. Annual program reports must cover at least the period July 1 to June 30.

m. Standard and Custom Reports.

(1) Contractor shall prepare and submit a suite of standard written reports at no cost to OHA. Contractor shall determine the technology it will use to develop the standard reports and how the reports will be shared with OHA. The suite of standard reports shall be defined by mutual agreement of the parties or as requested by OHA. Standard reports are defined as those which require little or no customization by OHA or Contractor.

(2) Custom reports are those reports for one-time use or those not included on the standard reports list below. Contractor shall prepare and submit to OHA up to ten additional written custom reports from data available from Contractor's database, as requested by OHA. Requests for additional custom reports in excess of ten shall be invoiced at a cost of $150.00 per hour for custom report development. Contractor must obtain written prior-authorization from OHA for any custom reports.

(3) OHA shall prepare a list of standard reports to be included in the standard report package. Contractor shall review, with OHA participation, the standard report package on a regular basis. Reports may be added to the standard reports list and those that are deemed not applicable to OHA or no longer required by OHA, may be eliminated from Contractor's regular distribution.

n. Contractor shall assess, measure and report FFS Client satisfaction as follows:

(1) FFS Client "Success Stories" provided on a quarterly and annual basis that detail resolution based upon Contractor's interventions and activities.

(2) FFS Client satisfaction information obtained during annual FFS Client satisfaction survey on an annual basis.

o. FFS Clients Grievances, Complaints, and Compliments. Contractor shall submit to the OHA OHPCC Contract Administrator and the HSD Medicaid Complaints and Grievances Coordinator a written report, in a format and frequency agreed upon by the parties or as requested by OHA, that contains FFS Client complaints, grievances, and compliments, including, but not limited to, the event, date, parties involved, follow-up and resolution.

15. Policies and Procedures.

a. Contractor shall implement and maintain written policies and procedures to ensure the FFS Client's rights, including:

(1) Confidentiality of medical information.

(2) Guarding against disclosure of confidential information to unauthorized persons.

(3) FFS Client's consent prior to release of confidential information, unless authorization is not required.

(4) Information about the FFS Client's rights to confidentiality.

(5) Client's rights and responsibilities related to participation in the Program.

(6) Client's rights to an OHA or State of Oregon fair hearing process.

b. Contractor shall provide OHA and DHS-APD access to review Contractor's policies and procedures for its Program.

c. Contractor shall be responsible for auditing the Program policies and procedures for compliance with federal, State, Oregon Health Plan, Oregon Health Authority, and Department of Human Services' statutes, rules, regulations and guidelines.

d. Contractor's Program communication policies and procedures shall include the inclusion of a Client's rights and responsibilities statement. The statement must be available on Contractor's internet and in Contractor's hard copy publications. The Client rights and responsibilities are included in Exhibit F of this Contract.

e. Contractor shall develop and maintain policies and procedures for the management and resolution of FFS Client and healthcare provider complaints, grievances, and compliments. Contractor's policies and procedures shall document and resolve each complaint and grievance event. Complaints, grievances, and compliments shall be reported to OHA as described in Section 13, subsection n.

Contractor's complaint and grievance policies and procedures shall not restrict any FFS Client's right to a State of Oregon fair hearings and appeals process.

16. Personnel.

a. Contractor shall ensure that Contractor's or Subcontractor's professional staff have and maintain the required education, experience, qualifications, licenses, and credentials for healthcare professionals in the positions to which they are assigned by Contractor, or Subcontractor.

b. Contractor shall maintain the operational capacity and staff levels to review complex OHP medical cases by appropriate healthcare staff during normal business hours of 8:00 a.m. to 5:00 p.m., Pacific Time, Monday through Friday, including State of Oregon and federal holidays.

c. Contractor shall have a contingency plan to manage any turnover in staff that has direct contact with FFS Clients; and to maintain an appropriate case manager-to-FFS Client ratio, to achieve the required outcomes as described in this Contract, as the Client populations fluctuate.

d. Contractor shall ensure that Contractor's telephone, on-site or video language service interpreters are qualified and certified to Oregon standards and comply with OAR 333-002-0000.

e. Key Persons. Contractor's Key Persons shall include the following positions. Contractor shall immediately notify OHA of any changes in its Key Persons. Individuals in the positions of privacy and security officer ~~and Native American liaison~~ may be less than 1.0 FTE or may serve other roles in the organization.

(1) Executive Director. The executive director shall be responsible for overall operations and efficiency.

(2) Clinical Operations Manager. The clinical operations manager shall be responsible for the day-to-day operations of the clinical services provided to all FFS Clients and the successful operation of the nurse triage and advice telephonic services. The clinical operations manager must have a Master's degree in a discipline related to the ~~Work~~ work or equivalent training and experience; and at least five years' experience. OHA reserves the right to review the equivalent training and experience to ensure it meets the needs of OHA.

(3) Medical Director. The medical director shall be responsible for developing and maintaining clinical protocols for FFS Clients, performing case reviews, and working with service providers and stakeholders in support of the OHP care coordination program. The medical director must have at least five years' experience as a medical director for an organization similar in size and scope to the Work under the Contract. The medical director position shall act in a consultative role for FFS Clients in support of OHA's Provider Clinical Support Unit and the Medicaid Medical Director.

(4) Privacy and Security Officer. The privacy and security officer shall be solely responsible for assuring HIPAA requirements are met and information systems are secure.

(5) Behavioral/Mental Health Assessments Manager. The behavioral and mental health assessments manager shall be accountable for all of the 1915(I) functions and all independent assessments for HCBS Recipients, and similar assessments for other FFS Clients required by OHA or DHS. This position must be a Licensed Qualified Mental Health Professional, with a master's degree, and have at least five years' experience with Medicaid populations.

f. Staffing for the Program.

(1) General Care Coordination. Contractor shall provide a qualified multidisciplinary team of registered nurses, primary care managers, social workers, disease management coordinators, and other licensed professionals as required for the Program.

(2) Field-based Staff. Contractor shall schedule field-based staff who may include registered nurses, social workers, provider-outreach staff, or community outreach staff to regularly visit high-volume or high utilization Medicaid fee-for-service hospitals and emergency departments, and federally qualified health centers.

(3) Field-based Staff Duties. Contractor shall ensure its field based staff duties include, but are not be limited to, the following:

(a) Communication with FFS Clients, healthcare providers, healthcare facilities, OHA, and family and caregivers regarding the FFS Client's healthcare and the development of plans-of-care and service plans that meet the FFS Client's needs.

(b) Responsibility to provide feedback to primary care physicians on FFS Client's status and progress.

(c) Provision of Case Management, Care Coordination, Disease Management, Intensive Care Management, interventions, assessments, education, and other clinically-based activities for FFS Clients.

(d) Performance of in-person, telephonic, text, E-mail, and any computer-based care management tools for assigned FFS Clients.

(e) Assistance and follow-up services with health-related, symptomatic, and emergent care calls received by the NAL.

(4) Care Management Coordinators. Contractor shall ensure its care management coordinators duties include, but are not limited to:

(a) Answer inbound NAL calls as described in Section 6 Nurse Triage and Healthcare Advice Line.

(b) Work with registered nurses and primary care managers to ensure Program services and supports are in place for FFS Clients.

(c) Communicate with community resources, healthcare providers and OHA regarding FFS Clients care coordination needs.

(d) Assist FFS Clients in scheduling appointments with physicians and specialists.

(e) Provide non-clinical assistance and self-management support to FFS Clients.

(f) Support the FFS Client-focused medical home concept.

(g) Conduct FFS Client needs assessments.

(5) Intensive Care Management. Contractor shall provide teams of primary care managers and care management coordinators for FFS Clients who meet ICM criteria based upon a health stratification process and risk assessment. Contractor's ICM registered nurse case manager duties include, but are not be limited to, the following:

(a) Develop and maintain relationships with hospital and clinic personnel for utilization review of contractor(s) for OHA.

(b) Develop systems for early intervention and coordination of discharge planning with hospitals.

(c) Provide FFS Client care management for complex cases and high utilizers of hospital emergency department services.

(d) Communicate with healthcare providers regarding FFS Client treatment needs and development of plans-of-care.

(e) Responsibility for medical records review, knowledge of individual ICM FFS Client's mental and physical history, and be

able to articulate FFS Client's history and communicate clinically to primary care physicians

(f) Provide Care Coordination and Intensive care management, assessment, education and other clinically based activities for FFS Clients.

(g) Perform in-person or telephonic Care Coordination.

17. Information Systems; Technology.

a. Contractor shall comply with, and require any Subcontractors to comply with, the information security requirements imposed by OHA or DHS. Contractor shall maintain security of equipment and storage of all information assets accessed through this Contract to prevent inadvertent destruction, disclosure, or loss.

b. OHA will provide Contractor with access to the claims information to support the Work indicated in this Contract. Contractor shall adhere to established OHA policies relating to access to this claims information including those described in Exhibit A Part 4, Section 8 HIPAA Compliance and Exhibit B Section 15 Information Privacy/Security/Access. Contractor shall complete an Individual User Profile request for each person for whom access is requested.

c. Contractor shall have an information security risk management plan and Contractor shall ensure the plan:

(1) Has established privacy and security measures that meet or exceed the standards established by this Contract and in accordance with OHA and DHS Privacy and Information Security Incident policies.

(2) Documents Contractor's privacy and security measures.

Contractor shall make its security risk management plan available to OHA for review upon request.

d. Contractor's information systems shall have the capacity and the capability to exchange information or claims data with OHA and DHS-APD for the number of FFS Clients eligible for OHP Care Coordination services and have the ability to increase capacity and capability as the need for services increases for the term of this Contract. Contractor shall have the computer capacity and capability to securely accept and transfer data using Secure File Transfer Protocol (SFTP).

e. FFS Client Management System. Contractor will use software applications or other information systems or assets for the selection, referral, and engagement of Program FFS Clients. Contractor shall ensure the proper handling, storage, and disposal of any information assets obtained or reproduced, when the authorized use of that information ends, consistent with the record retention requirements otherwise applicable to this Contract.

f. Contractor shall have systems to monitor the operation of Contractor's Program that include silent monitoring of care managers or coordinators, NAL, Disease Management, and Intensive Care Management telephone calls; and can create

monthly metrics reports of the Contractor's NAL activity as required under Section 13 Data, Records and Reports.

g. Contractor shall have systems to assist in supervising and managing the performance of its personnel as it applies to the Program.

h. Work performed under this Contract requires Contractor to have access to the Chronic Disease Payment System (CDPS) and the Medicaid Management Information System (MMIS). Contractor shall comply with Exhibit B Section 15 Information Privacy/Security/Access.

18. Advance Directives.

Contractor shall support adults having advance directives to assist in guiding their health care decisions.

a. Contractor shall maintain written policies and procedures concerning advance directives with respect to all adult FFS members receiving services.

b. Contractor shall provide adult members with information on advance directives and where to receive additional information on completing an advance directive. The information provided by Contractor must reflect changes in Oregon law as soon as possible, but no later than 90 calendar days after the effective date of any change to Oregon law.

19. Independent Contractor

a. Contractor shall act at all times as an independent contractor and not as an agent or employee of OHA. Contractor has no right or authority to incur or create any obligation for or legally bind OHA in any way. Although OHA reserves the right to evaluate the quality of the completed performance and determine and modify the delivery schedule for the services to be performed, OHA cannot and will not control the means or manner by which Contractor performs the services, except to the extent the means and manner in which the services are to be provided is specifically set forth in the applicable Statement of Work. Contractor is responsible for determining the appropriate means and manner of performing the services. Contractor acknowledges and agrees that Contractor is not an "officer", "employee", or "agent" of OHA (or any other agency, office, or department of the State of Oregon), as those terms are used in ORS 30.265, and shall not make representations to third parties to the contrary.

b. To maintain its independent contractor status and to mitigate the risk of Contractor's onsite staff being identified as State employees, Contractor agrees to the following:

(1) Contractor's employee identification badges shall clearly identify them as a Contractor.

(2) Contractor's employees shall have their own business cards.

(3) Contractor shall not approve deliverables, travel expenses or invoices, but may review them at the request of OHA.

(4) Contractor shall not be listed on OHA phone or email lists without the contractor status being highlighted.

(5) Contractor shall not be a voting member on solicitation evaluation committees, shall not attend normal OHA staff meetings, and shall not participate in OHA employee awards or recognition programs unless specified in this Contract.

(6) Contractor shall not request reimbursement or be paid for business expenses, including travel, unless specified in this Contract.

(7) Contractor's email signature should not suggest Contractor's staff is representing OHA without designating they are a contractor.

(8) OHA shall not train Contractor's staff or reimburse Contractor for training or provide orientations for Contractor's staff unless specified in this Contract.

(9) OHA shall provide those facilities and equipment, as specified in Section 18 Use of OHA Facilities and Equipment, required for Contractor to complete the Work.

ATTACHMENT 2:

EXHIBIT A

Part 3
Payment and Financial Reporting

1. Invoicing.

a. Contractor shall send all invoices to OHA's Contract Administrator at the address specified on page one of this Contract, or to any other address or designee as OHA may indicate in writing to Contractor.

b. Contractor shall submit to the OHA Contract Administrator by the 15th of each month an invoice for contracted services rendered the previous month. The monthly invoice shall be accompanied with reports in a mutually agreed upon format, that detail eligibility counts to substantiate the billing amount

c. Invoices shall include the total amount invoiced to date by the Contractor prior to current invoice. Contractor will note in the appropriate invoice when one-third and two-thirds of the maximum not-to-exceed amount is reached.

2. Travel and Other Expenses.

OHA will not reimburse Contractor for any travel or additional expenses under this Contract.

3. Provider Payments.

Contract does not include contracted service provider networks and Contractor will not be the payer of medical treatments or procedures rendered to the FFS Client.

4. Method of Payment.

a. Payment for all work performed under this Contract shall be subject to the provisions of ORS 293.462 and shall not exceed the maximum not-to-exceed amount in Section 3. Consideration. The not-to-exceed amount is budgeted according to the following:

Contract Not to Exceed Amount (NTE)			**$27,289,270.00**
Service	**Unit Measure**	**Unit Rate**	**Not to Exceed**
1915(i) Evaluation/Reevaluation **(IQA)**	1 Service	$57.75	**$7,729,663.00**
1915(i) Person Centered Plan Development **(IQA)**	1 Service	$107.25	
AFH- Medical Appropriateness Review **(non- 1915(i)-eligible**	1 Service	$110.00	

individuals)			
RTH/F- Medical Appropriateness Review **(non- 1915(i)-eligible individuals)**	1 Service	$115.00	
SRTF- Medical Appropriateness Review	1 Service	$125.00	
Behavioral Health Prior Authorization by QMHP	1 Service	$135.00	
Medical review/consult by MD	1 Service	$650.00	
Treatment Episode Monitoring AFH/RTH/RTF **(non-1915(i)-eligible individuals)**	1 Service	$90.00	
Treatment Episode Monitoring SRTF	1 Service	$115.00	
Concurrent Review – Inpatient Hospital	1 Service	$605.00	
Monthly Residential Census and report	1 Service	$2,000.00	
OSH Conflict Free case management	1 hour	$96.00	
FFS Conflict Free case management	1 hour	$96.00	
Nurse Triage and Advice Line	1 Month	$29,320.00	$1,055,520.00
Care Coordination services	1 per member per month	$3.90	$16,848,000.00
Claim Reevaluation services for CAWEM claims	1 Service	$50.00	$992,250.00

~~Optional~~ Pay for Performance		Not to Exceed $663,837.00	
Area	**Target**	**Incentive**	**Not to Exceed**
OHA shall award Contractor a one-time performance payment for each patient assisted - by Contractor to discharge from the Oregon State Hospital when the performance target is met.	~~Discharge less than 30 days from determination of ready to transition~~	~~$500.00 per patient per discharge~~	~~**$5000.00 per month**~~
	~~Discharge less than 25 days from determination of ready to transition (RTT)~~	~~$700.00 per patient per discharge~~	~~**$7000 per month**~~
	Discharge less than 20 days from determination of ready to transition (RTT)	$800.00 per patient per discharge	**$8000 per month**
	~~Discharge less than 15 days from determination of ready to transition (RTT)~~	~~$1000.00 per patient per discharge~~	~~**$10000 per month**~~
~~Secure Residential Treatment (SRTF) Utilization~~	~~Maintain 180 day average length of stay for members in SRTF~~	~~$1000 per member assisted to discharge to a lower level of care from an SRTF~~	~~**$10,000 per month**~~
~~*The one time pay for performance will account for Recipient maintaining a successful lower level (least restrictive placement) for 180 days. If a Recipient returns to RTT within 180 days of initial placement by Contractor, Contractor will not be eligible to receive an additional performance payment for that Recipient if the Recipient returns to the Oregon State Hospital within 180 days of step down.~~			

5. Budget Neutrality.

Contractor must demonstrate that the Program is at least budget neutral, in that the Program will save enough money in health care costs to pay for itself. All rates paid for services will be evaluated by OHA and DHS-APD and are subject to evaluation of cost-effectiveness by the Centers for Medicare Services (CMS). Contractor must work to reduce overall Program expenditures.

OHA will continue to pay all medical claims for services provided to Clients and will track utilization of services prior to Contractor's Program implementation and on a quarterly basis, according to CMS rules under waivered programs. Contractor and OHA will develop a mutually acceptable budget neutrality methodology document to detail the process, timetable, exclusions, and other parameters of the budget neutrality calculation. The Contractor will not assume financial risk for budget neutrality.

6. Liability for Payment.

Contractor understands and agrees that under no circumstances will a Client be held liable for any payments for any of the following:

a. Contractor's or Subcontractor's debt due to Contractor's or Subcontractor's insolvency;

b. Healthcare services authorized or required to be provided under this Contract to the Client, for which:

(1) OHA does not pay the Contractor; or

(2) Contractor does not pay a provider or Subcontractor that furnishes the services under a contractual, referral, or other arrangement; or

(3) Payments for covered services furnished under a contract, referral or other arrangement with Subcontractors, to the extent that those payments are in excess of the amount that the Client would owe if the Contractor provided the services directly.

Nothing in this Section limits Contractor, OHA, a provider or Subcontractor from pursuing other legal remedies that will not result in the Client's personal liability for such payments.

7. Risk of Insolvency.

a. Contractor assures that it is able to perform the Work required under this Contract efficiently, effectively and economically and is able to comply with the requirements of this Contract. As part of the proof of financial responsibility, Contractor shall provide assurances satisfactory to OHA, that Contractor's provision(s) against the risk of insolvency are adequate to ensure that Clients will not be liable for Contractor's debts if Contractor becomes insolvent.

b. Contractor shall provide solvency protection through maintenance of a restricted reserve account, or other means approved by OHA.

(1) Funds held in the restricted reserves, if any, shall be made available to OHA for the purpose of making payments to providers in the event of Contractor's insolvency. Insolvency occurs when Contractor is unable to pay debts when due, even if assets exceed liabilities.

(2) If any of the information that forms the basis for determining the manner or amount of a restricted reserve account is eliminated, changed, or modified in any manner, Contractor shall immediately notify OHA.

(3) Failure to maintain adequate financial solvency, including solvency protections specified pursuant to the requirements of this Contract, shall be grounds for termination, reduction in service area or enrollment, or sanction under this Contract, at OHA's sole discretion.

c. Contractor shall have procedures and policies to assure that Clients will not be liable for any debts or payment of claims in the event a Subcontractor becomes insolvent. All Subcontracts will include a clause that the Subcontractor will look only to the Contractor, and under no circumstances to the Client, for full payment of claims, and shall further require that this clause survives the termination of this Contract or Subcontract, including breach of Contract or Subcontract due to insolvency.

d. In the event that insolvency occurs, Contractor remains responsible for providing covered services for Clients through the end of the period for which it has been paid.

Attachment 4 – ~~IQA~~ Rates and Metric and Performance Tables

1. Rates for ~~IQA~~ Services to Individual Recipients Including 1915(i) HCBS State Plan Amendment IQA Services.

Service	Unit	Rate
OSH – CONFLICT FREE CASE MANAGEMENT	1 hour	$96.00
FFS – CONFLICT FREE CASE MANAGEMENT (IQA for 1915(i) FFS)	1 hour	$96.00
MEDICAL APPROPRIATENESS REVIEW (POC) – AFH-(NON-1915(i) ELIGIBLE INDIVIDUALS)	1 Service	$110.00
MEDICAL APPROPRIATENESS REVIEW (POC) – RTH (NON-1915(i) ELIGIBLE INDIVIDUALS)	1 Service	$115.00
MEDICAL APPROPRIATENESS REVIEW (POC) - RTF(NON-1915(i) ELIGIBLE INDIVIDUALS)	1 Service	$115.00
MEDICAL APPROPRIATENESS REVIEW (POC) - SRTF	1 Service	$125.00
QMHP – MEDICAL APPROPRIATENESS REVIEW – PRIOR AUTHORIZATION (IQA)	1 Service	$135.00
MD – MEDICAL APPROPRIATENESS REVIEW / CONSULTATION	1 hour	$650.00
TREATMENT EPISODE MONITORING – AFH (NON-1915(i) ELIGIBLE INDIVIDUALS)	1 Service	$90.00
TREATMENT EPISODE MONITORING – RTH (NON-1915(i) ELIGIBLE INDIVIDUALS)	1 Service	$90.00
TREATMENT EPISODE MONITORING – RTF (NON-1915(i) ELIGIBLE INDIVIDUALS)	1 Service	$90.00
TREATMENT EPISODE MONITORING - SRTF	1 Service	$115.00
1915(i) ELIGIBILITY DTERMINATION (IQA)	1 Service	$120.00
RESIDENTIAL CENSUS AND REPORT	1 Service	$24,000

2. Metrics and Performance.

Work Area: Conflict Free Case Management
Focus Area: Oregon State Hospital
~~**Contract Base Requirement – July 1, 2016 through June 30, 2017**~~
~~**Base Metric = 75% of patients determined discharge ready will discharge within 30 calendar days of determination**~~
~~***Optional pay for performance metric: July 1, 2016 through end of contract. ****~~
~~Provider will invoice OHA monthly for work performed. Monthly, OHA shall award contractor a one time performance payment of **$500** for each patient assisted to discharge less than **30** days on the ready to transition list (RTT). Not to exceed $5,000 per month / per invoice. or;~~
~~Provider will invoice OHA monthly for work performed. Monthly, OHA shall award contractor a one time performance payment of **$700** for each patient assisted to discharge less than **25** days on the ready to transition list (RTT). Not to exceed $7,000 per month / per invoice. or;~~
~~Provider will invoice OHA monthly for work performed. Monthly, OHA shall award contractor a one time performance payment of **$800** for each patient assisted to discharge less than **20** days on the ready to transition list (RTT). Not to exceed $8000 per month / per invoice. or;~~
~~Provider will invoice OHA monthly for work performed. Monthly, OHA shall award contractor a one time performance payment of **$1000** for each patient assisted to discharge less than **15** days on the ready to transition list (RTT). Not to exceed $10,000 per month / per invoice.~~
~~**Contract Base Requirement – July 1, 2017 through June 30, 2018**~~
~~85% of patients who are determined discharge ready will discharge within 25 calendar days of determination~~
Contract Requirement – July 1, 2018 through contract end date
90% of patients who are determined discharge ready will discharge within 20 calendar days of determination
Optional pay for performance metric: Effective date of contract amendment 4 ~~July 1, 2016~~ through end of contract. *
~~**Provider**~~ **Contractor will invoice OHA monthly for work performed. Monthly, OHA shall award contractor a one-time performance payment of $800 for each patient assisted by Contractor to discharge and was discharged within 20 days of being determined Ready to Transition (RTT). Not to exceed $8000 per month / per invoice.**
~~**Scope of Work: Medical Appropriatness Reviews / Treatment Episode Monitoring**~~
~~**Focus Area: Secure Residential Treatment Facilities**~~
~~**Contract Requirement – July 1, 2016 through June 30, 2017**~~
~~**Base Metric = By the end of year one, there will be a 10% reduction from the baseline average length of stay.**~~
~~**Contract Requirement – July 1, 2017 through June 30, 2018**~~
~~20% reduction from the baseline average length of stay.~~
~~**Contract Requirement – July 1, 2018 through contract end date**~~
~~Maintain 180 day average LOS for SRTF~~
~~***Optional pay for performance metric: July 1, 2016 through end of contract. ****~~
~~Provider will invoice OHA monthly for work performed. Monthly, OHA shall award contractor a performance payment of **$1000** for each member assisted to discharge to a lower level of care from an SRTF. Not to exceed $10,000 per invoice.~~

~~*The one time pay for performance will account for Recipient maintaining a successful lower level (least restrictive placement) for 180 days. If a Recipient returns to RTT within 180 days of initial placement by Contractor, Contractor will not be eligible to receive an additional performance payment for that Recipient if the Recipient returns to the Oregon State Hospital within 180 days of step down.~~